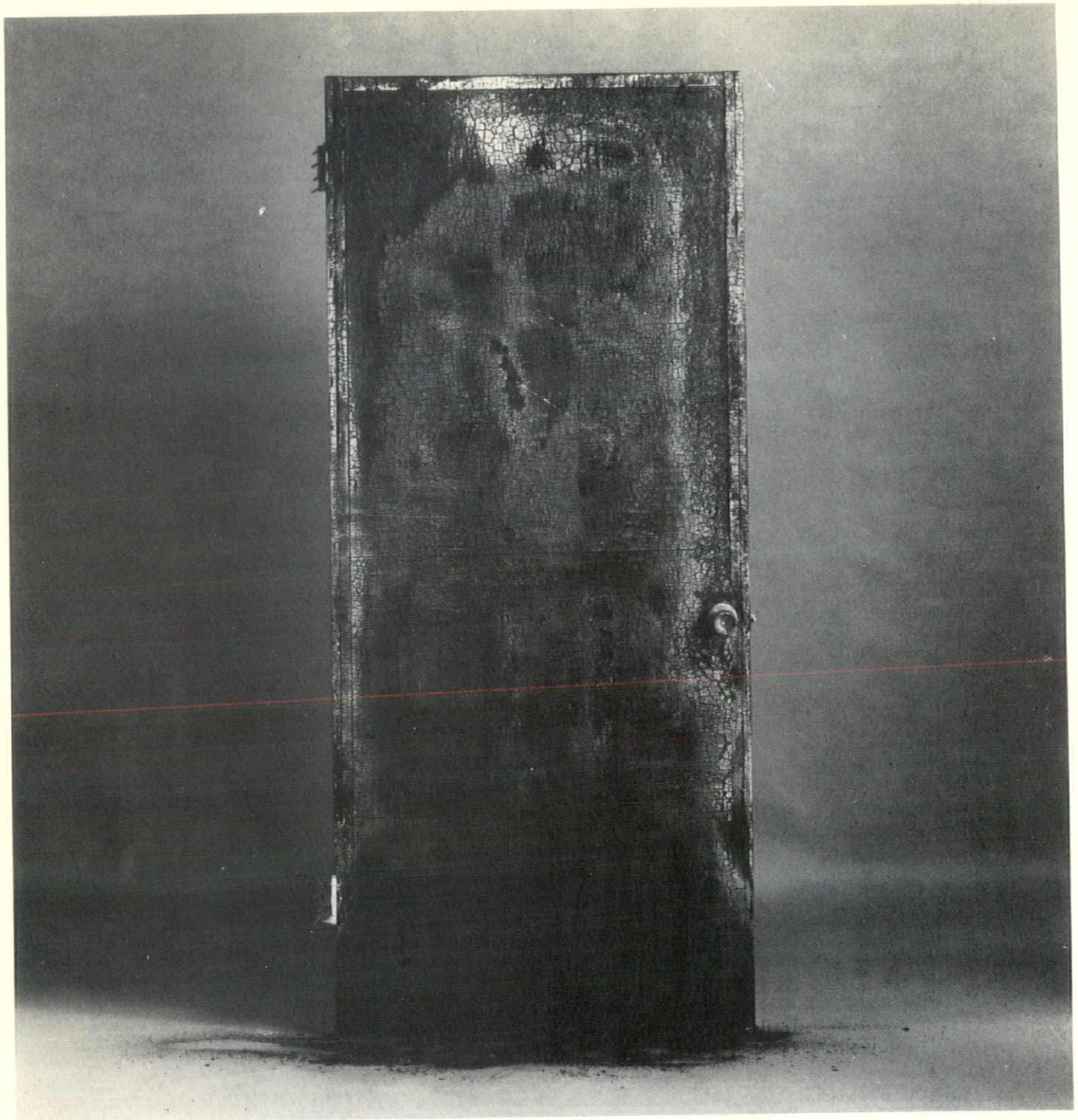
# EMPIRE STATE ARCHITECT



HEALTH FACILITIES

MARCH 1972



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THE STATE ORGANIZATION OF THE AIA

# EMPIRE STATE ARCHITECT

MARCH 1972 VOLUME 32, NUMBER 1



IN THIS ISSUE



COVER: Symbol for a Health Facility for use in New York City as recommended by the Architectural Graphics Manual published by the Health & Mental Hygiene Facilities Improvement Corporation, January 1971.



All correspondence regarding subscriptions, advertising and other inquiries for information should be addressed to Mr. Harry Gluckman, 126 South Elmwood Avenue, Buffalo, New York 14202.

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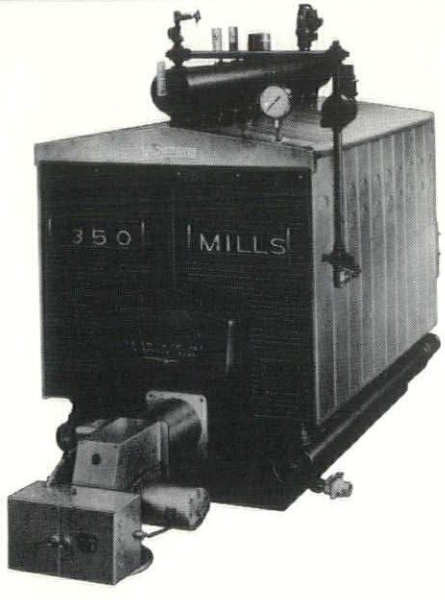


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# letter to the editor

Editor:

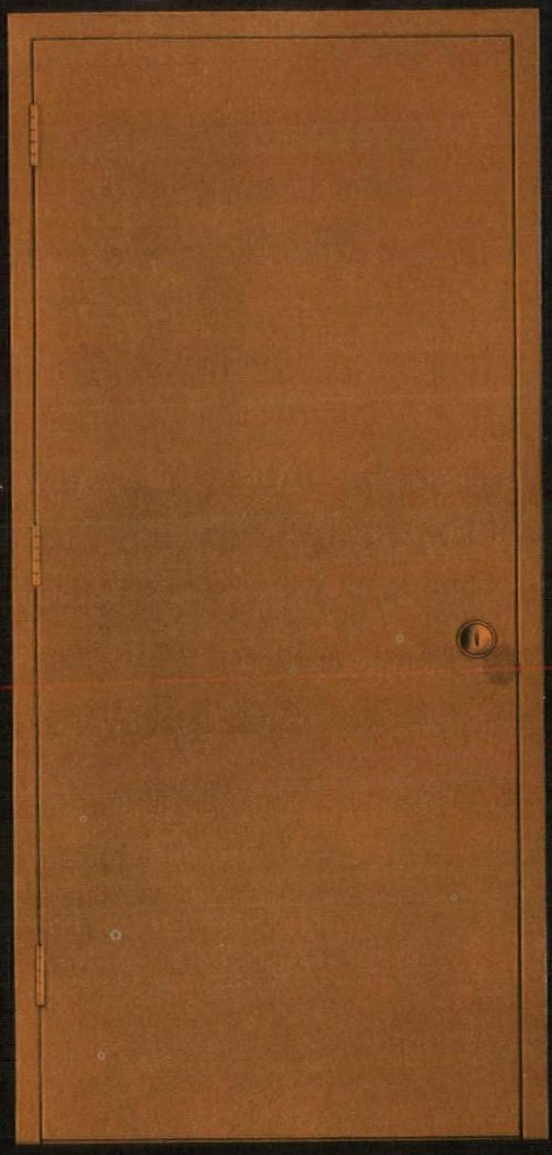
In reference to the article by Norman A. Coplan, Esq. published in the December 1971 issue of Empire State Architect entitled "Changes in the Education Law of the State of New York Regulating the Professional Practice of Architecture," it is my opinion that all architects of New York State, in particular the general practitioner with a smaller office should be very concerned about the legislatures current changes to the definition of what constitutes architectural practice. It is my opinion that the current definition severely restricts the practice of architecture. The definition quoted from Mr. Coplan's article stipulated architectural practice as "services in connection with the design and construction of structures which have as their principle purposes, human habitation and use, and the utilization of space within such structures, including the performing of planning, designs, drawings, specifications, construction management and the administration of construction contracts where the safeguarding of life, health and property is involved."

The original definition contained in the New York State Education Law Article 147 "Architecture", Section 7301 "Definitions", paragraph 3 defines the practice of architecture as "consultation, investigation, evaluation, planning, design, including aesthetic and structural design or responsible supervision of construction with any private or public buildings, structures or projects or the equipment or utilities thereof, wherein the safeguarding of life, health or property is concerned or involved, when such professional service requires the application of the art and science of construction based upon the principles of mathematics, aesthetics and the physical sciences."

The foregoing original definition is a far better description of what architectural education trains an architect to do than what is currently proposed; it also reflects the examination requirements for Architectural Licensing in New York State and it is a very accurate description of what an architect, especially in a smaller firm without permanent specialist engineering consultants, must do on a daily basis. It appears to me that a definition of architectural practice should include the words "consultation, investigation and evaluation" because that is what we do. "Planning should not be as implied in the proposed amendment as something that is concerned simply with the "utilization of space within such structures." Architects must be concerned, involved and free to plan the land and sites on which their structures are located. "Structural design" is not mentioned in the proposed amendment and yet it is one of the cornerstones of our professional education. Without the right to design structurally, an architect cannot function. "Private or public buildings, structures or projects" appears to me to be a pretty good description of what area an architect has traditionally concerned himself with. The original definition included non-utilitarian or non-habitable structures or projects such as monuments and purely decorative structures which could be excluded by strict definition of the current amendment. The original definition included the "consultation, investigation, evaluation, planning, design . . . .of equipment or utilities or accessories thereto" for the private or public building structures or projects. The current amendment says nothing of this. If architects are prevented from exercising this part of their practice it will severely hamper their activities especially in the smaller office where the architect must exercise all of the resources of his training and the rights which he was granted under the original Education Law.

(continued on page 5)

# Introducing... Acousta-Door, noise can't go in or come out.



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**LETTER — continued**

I strongly believe that the architect is again being put down, his rights and privileges stripped away by a legislature, begging Mr. Coplan's pardon, which is dominated by members of the legal profession who haven't the least notion of what architectural practice is. We have seen year after year bills dangerous to architectural practice brought forth by the legislature and then in panic and a flurry of activity we manage to defeat them. We see year after year bills intended to benefit architects and their practice, such as the Statute of Limitation Bill, defeated by the State. The present move to redefine architectural practice, as we know it today, out of existence and to negate the hard won professional privileges which we as architects have enjoyed, is far more insiduous.

It must be defeated. I do not see why the definition of architectural practice has been changed and I do not see how it can remain changed to the present form without taking away some of our important professional perogatives. All of the practicing architects in New York State licensed under examination have conformed to the educational and examination requirements required by the State in order to fulfill the definition of practice as set forth in the definition contained in the original Education Law. How can we continue to practice our profession if we are to be limited in our natural duties and services? Are we to seize upon the new role of construction manager which the new definition has thrust upon us and abdicate our role as the leader of the construction and planning design team?

We cannot let a legislature dominated by the legal profession, which has no sympathy or understanding of architectural practice, emasculate us. On the face of Mr. Coplan's account of the change in the definition of architectural practice, I see no choice but a strong stand including a search for legal redress if the legislature cannot be persuaded to restore our professional rights and privileges. Mr. Coplan says that "apparently it was the intention of the legislature to broaden the definition of what constitutes the practice of architecture." The intentions are less important to me as an architect than the results, which are a definite restriction, not a broadening, of the definition of architectural practice. It matters not whether this is a deliberate move by forces seeking to limit the scope of architectural practice or whether the restrictive definition came about through blind ignorance and insouciance, the end result is that we the architects are the victims. If we do not protest and reverse this move we will deserve what we get.

I urge you as the President of the New York State Association of Architects to take the appropriate action through the State organization to protect the rights of all New York State Architects against the unfortunate restrictions contained in the Amendment to the Education Law. I also urge all individual chapters of the A.I.A., especially their Legislative Committees, to take appropriate individual and collective action to reverse the actions of the Legislature.

Yours very truly,

LeRoy F. van Lent, R.A., AIA

**NEXT ISSUE ESA – JUNE 1972**

**Will Feature the Membership Roster**

**Copy/Ad deadline is May 10th.**

# Health Facilities

## A REPRESENTATIVE SERIES

The following 12 pages are Presentations showing comprehensive proposed buildings for Health Facilities throughout the State.

North Shore Hospital, Extended Care Facility,
Manhasset, L.I., New York
Ferrenz & Taylor, New York

The Mary Imogene Bassett Hospital
Cooperstown, New York
Skidmore, Owings & Merrill, Architects, N.Y.

Ferncliff Nursing Home
Rhinebeck, New York
Belfatto & Pavarini, New York

Wesley Nursing Home, Inc., Saratoga Retirement Center
Saratoga Springs, New York
Donald J. Stephens Associates, Loudonville, N.Y.

Northern Westchester Hospital Center
Mount Kisco, New York
Kiff Voss & Franklin – The Office of York & Sawyer, New York

Mohawk Valley Nursing Home, Mohawk Valley General Hospital
Ilion, New York
Cannon Partnership, Buffalo

Samaritan Hospital Development Program
Troy, New York
E. Todd Wheeler and The Perkins & Will Partnership, White Plains, N.Y.

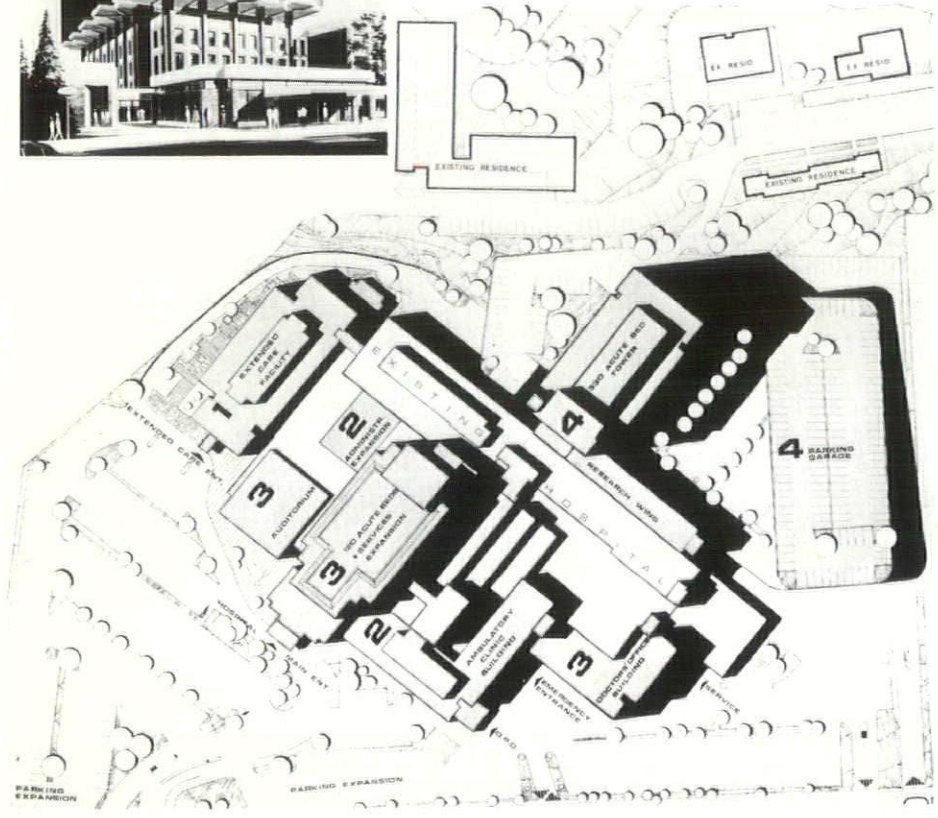
Park Ridge Nursing Home
Greece, New York
Corgan & Balestiere, Rochester

Brookdale Hospital Center, Extended Care Facility
Brooklyn, New York
William N. Breger Associates & Unger/Napier Associates, New York

Daughters of Jacob Geriatric Center, Nursing Home & Health Related Facility
Bronx, New York
Blumenkranz & Bernhard, New York

Peninsula Nursing Home, Peninsula General Hospital
Edgemere, New York
Schuman, Lichtenstein & Claman, New York

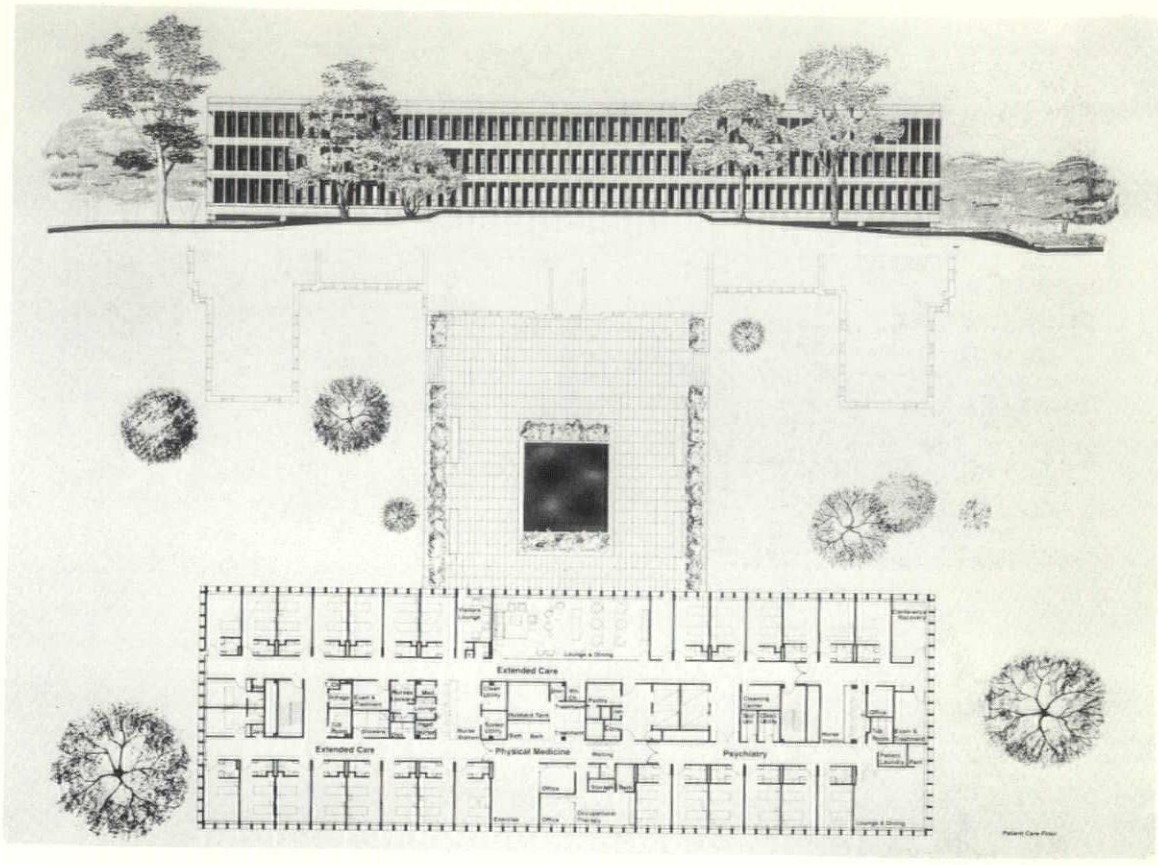
St. Joseph's Hospital
Syracuse, New York
King & King, Syracuse, New York

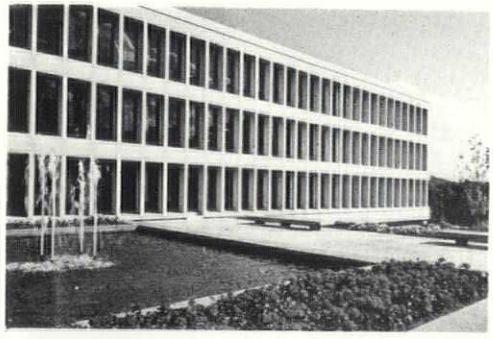



# North Shore Hospital, Extended Care Facility

Manhasset, Long Island, New York

FERRENZ & TAYLOR, New York, N.Y.

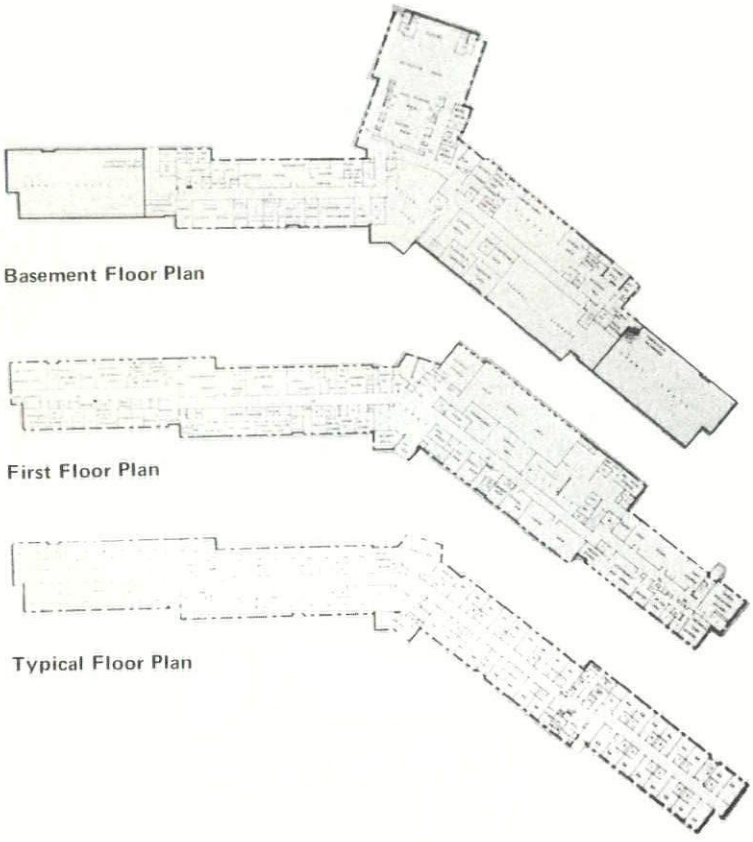


# The Mary Imogene Bassett Hospital

Cooperstown, New York

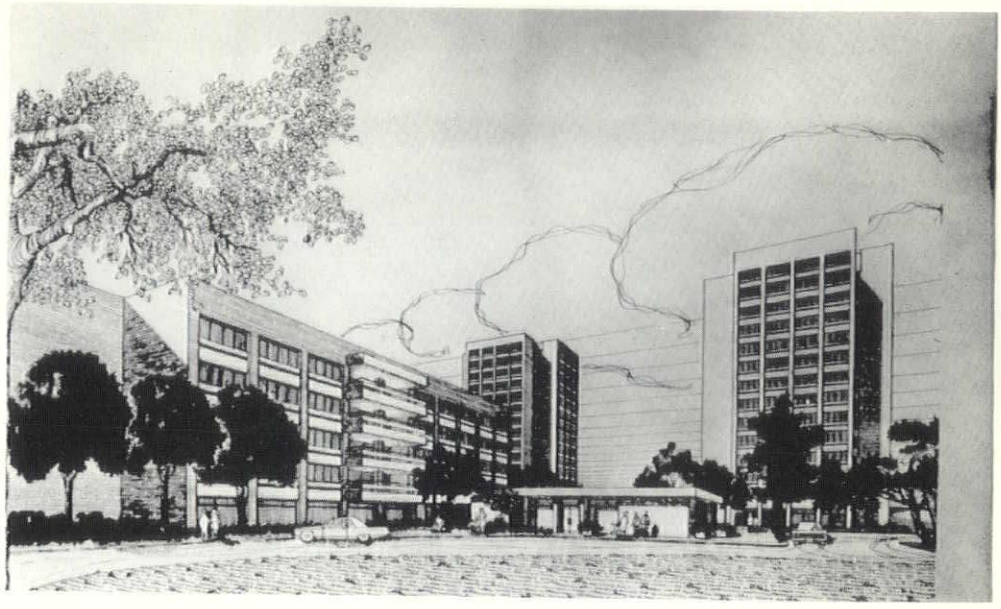
SKIDMORE, OWINGS & MERRILL, ARCHITECTS, New York, N.Y.

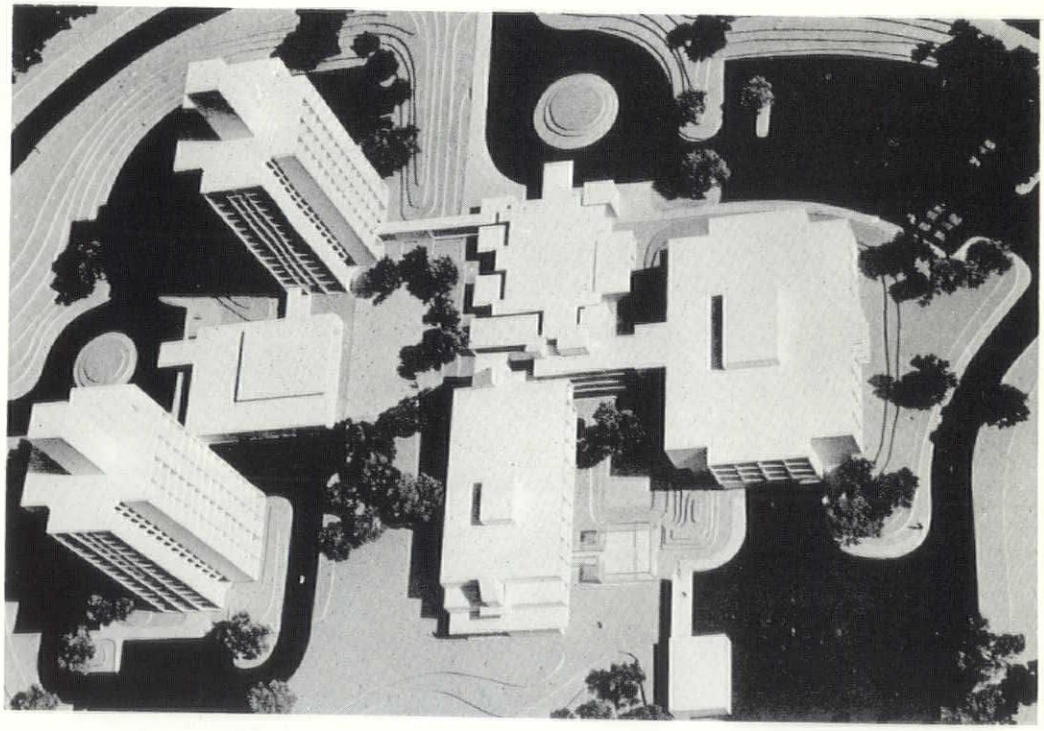



# Ferncliff Nursing Home

Rhinebeck, New York

BELFATTO & PAVARINI, New York, N.Y.

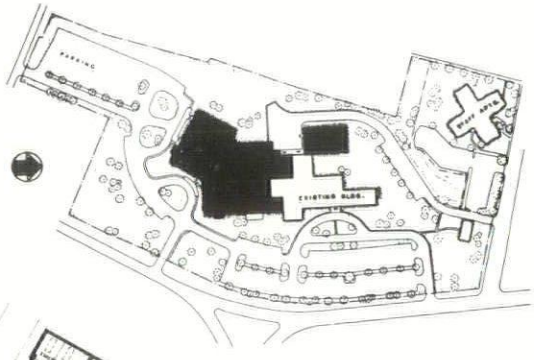


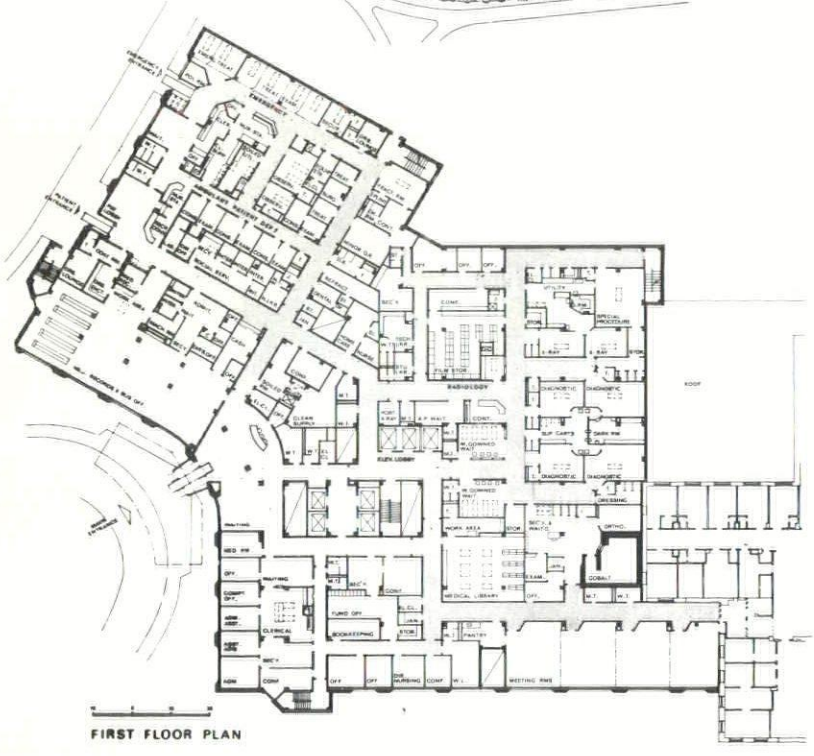


# Wesley Nursing Home, Inc.
# Saratoga Retirement Center

Saratoga Springs, New York

DONALD J. STEPHENS ASSOCIATES, Loudonville, N.Y.



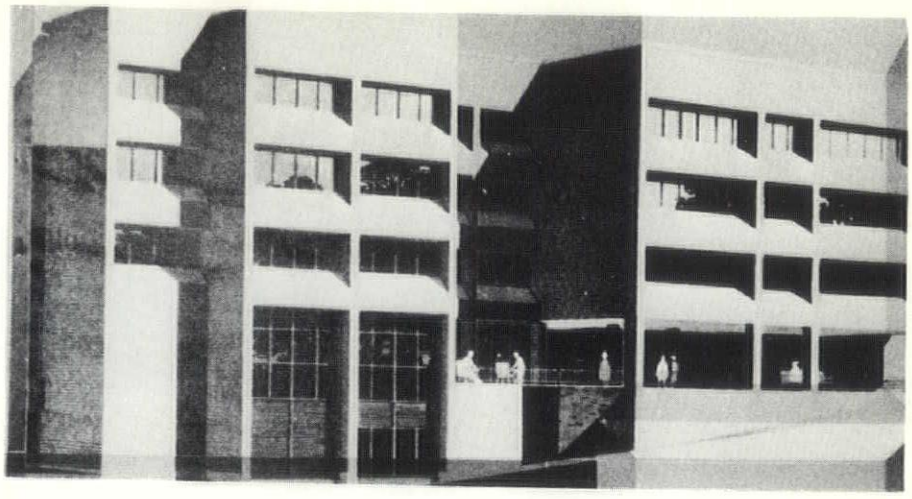



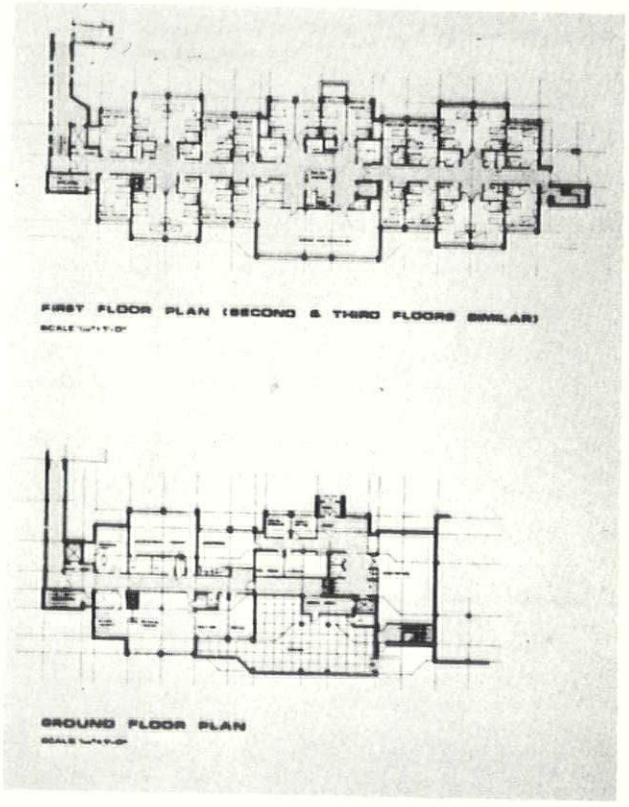

FIRST FLOOR PLAN

# Northern Westchester Hospital Center

Mount Kisco, New York

KIFF VOSS & FRANKLIN – THE OFFICE OF YORK & SAWYER, New York, N.Y.



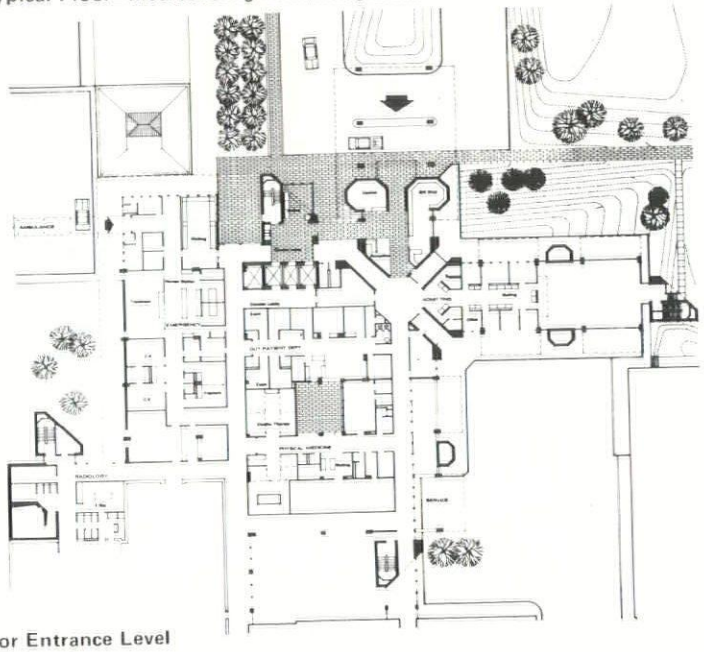



# Mohawk Valley Nursing Home, Mohawk Valley General Hospital

Ilion, New York

CANNON PARTNERSHIP, Buffalo, N.Y.

Typical Floor—Medical-Surgical Nursing Units

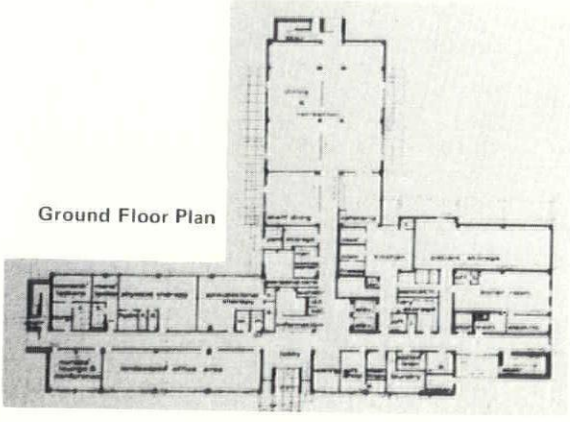


Main Floor Entrance Level

# Samaritan Hospital Development Program

Troy, New York

E. TODD WHEELER and THE PERKINS & WILL PARTNERSHIP, White Plains, N.Y.

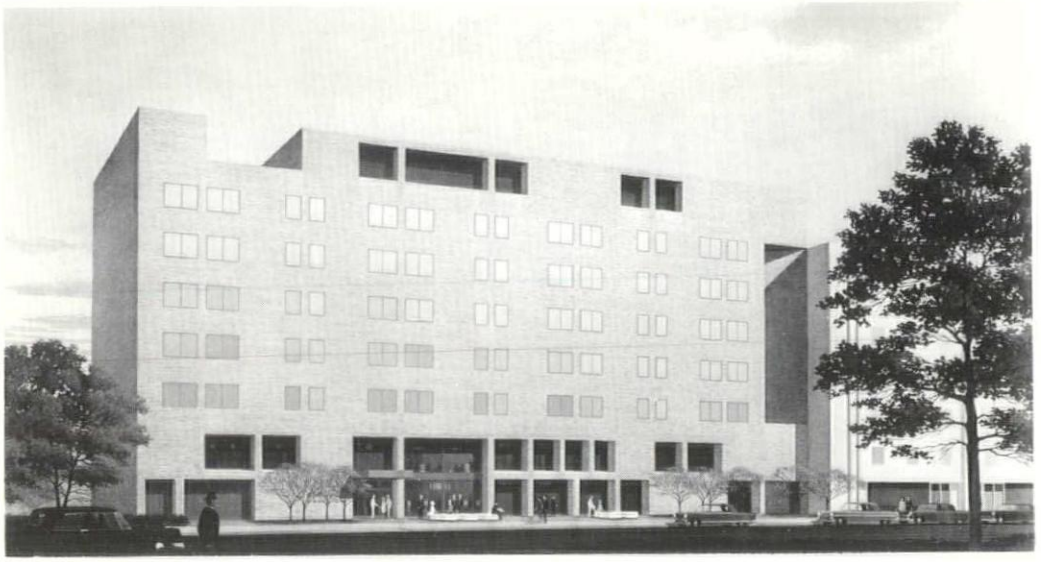


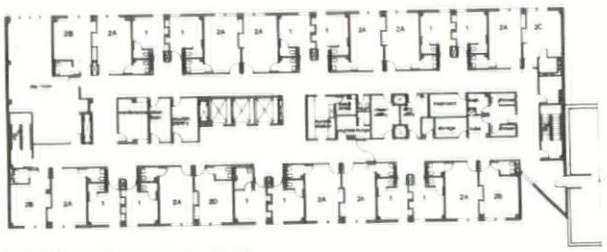


# Park Ridge Nursing Home

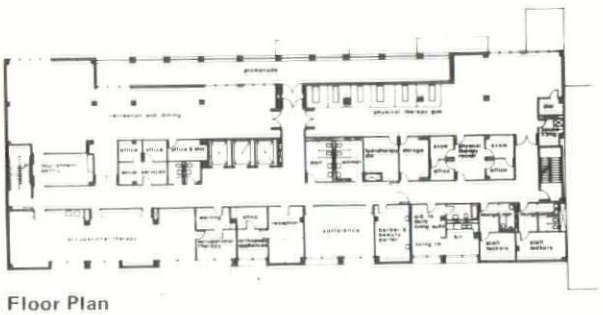
Greece, New York

CORGAN & BALESTIERE, Rochester, New York

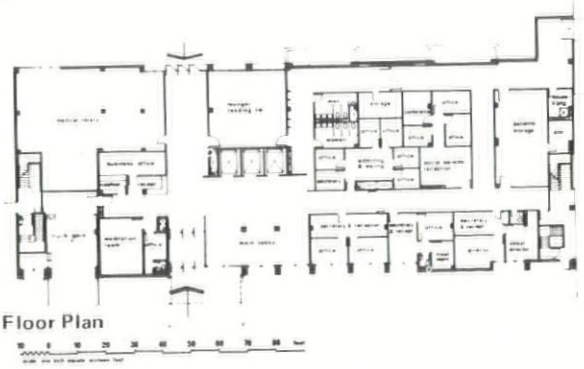




Typical Floor Plan (3rd–7th)



2nd Floor Plan

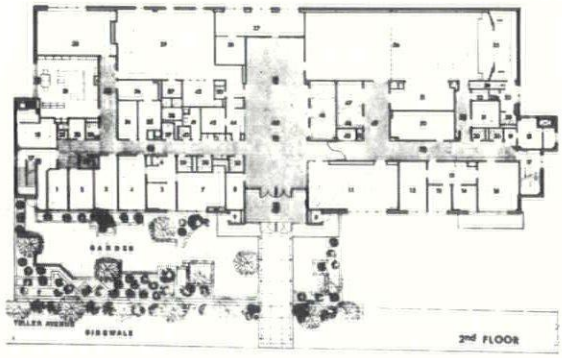


1st Floor Plan

# Brookdale Hospital Center, Extended Care Facility

Brooklyn, New York

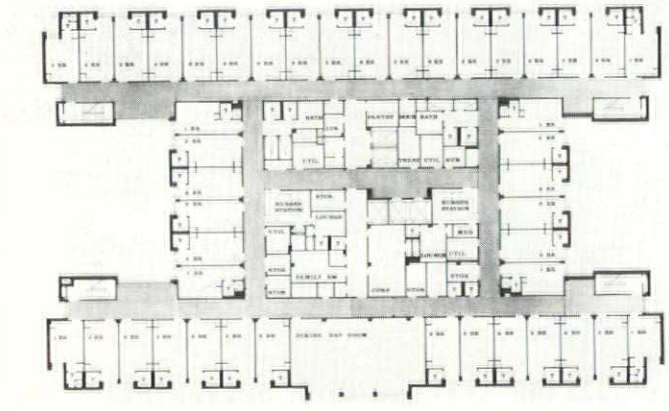
WILLIAM N. BREGER ASSOCIATES & UNGER/NAPIER ASSOCIATES, New York, N.Y.

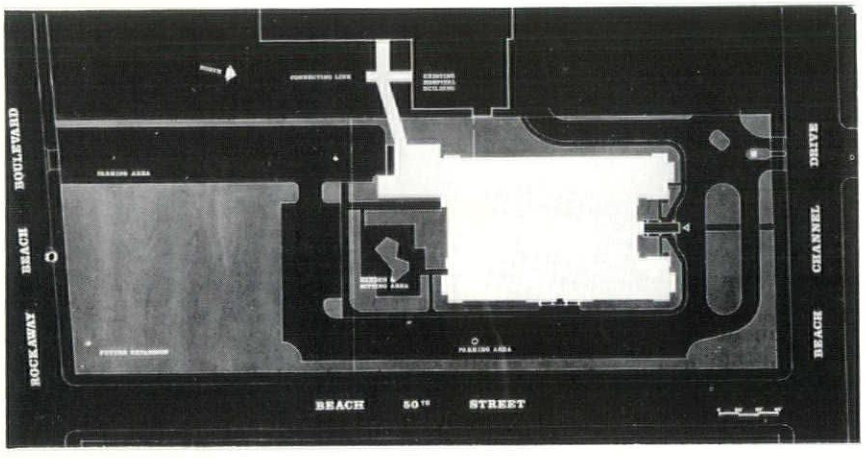

# Daughters of Jacob Geriatric Center, Nursing Home & Health Related Facility

Bronx, New York

BLUMENKRANZ & BERNHARD, New York, N.Y.



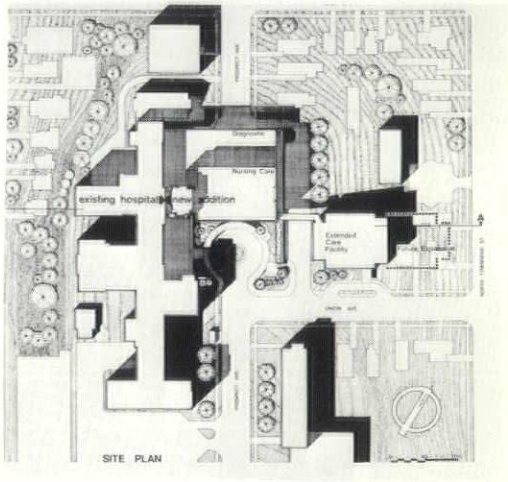
Typical Floor

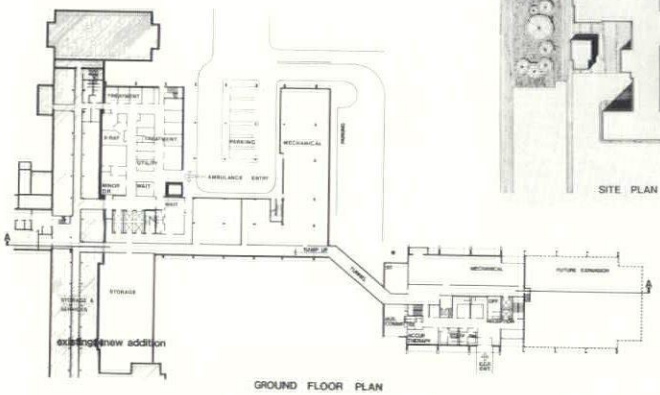


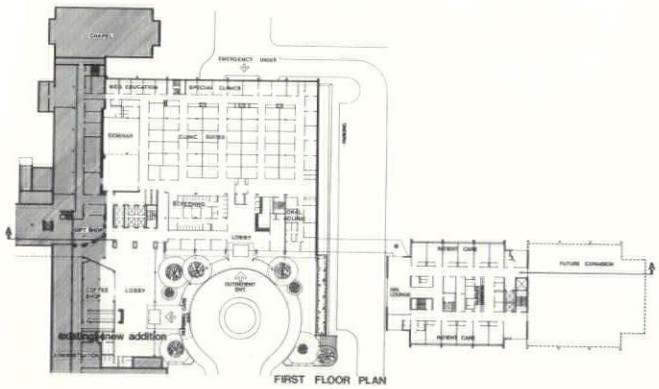

# Peninsula Nursing Home, Peninsula General Hospital

Edgemere, New York

SCHUMAN, LICHTENSTEIN & CLAMAN, New York, N.Y.




# St. Joseph's Hospital

Syracuse, New York

KING & KING, Syracuse, New York

# Ambulatory Care Facilities Seminar Announced For April 27, 1972

The Hospital and Health Committee of the New York State Association of Architects/AIA and the New York State Department of Health announce a seminar on Ambulatory Care Facilities to be held at the Campus Center, Uptown Campus, New York State University at Albany, April 27, 1972.

The Spring seminar, the sixth in a series on trends in hospital architecture of the 1970's, is open to architects, engineers and hospital staff personnel. The one-day seminar will present case studies of the various concepts for delivery of ambulatory care including hospital based centers, non-hospital based centers in urban and rural environments both public and private, prepaid and fee-for-service.

Speakers will discuss an ambulatory care facility describing the facility in light of the type of care system employed and its functional program requirements. A question and answer period will follow each presentation. Program speakers include: Robert L. Boyar, Director, N. Y. City Health & Hospital Corporation, who will discuss Neighborhood Family Care Centers; Aldo Giaccino, Director of Planning, HIP of New York; Robert Biblo, Director, Harvard Community Health Program; Harold M. Gardner, M.D., Medical Director, Genesee Valley Group Health Association, Rochester; A. Hugh Ferguson, Business Manager Doctors Offices, Columbia Presbyterian Medical Center, New York; Frazer Mooney, Assistant Administrator, E. J. Meyer Hospital, County based care center, Buffalo; Dr. Beatrice Kresky, Deputy Director, Comprehensive Health Planning Agency, New York City; John Nelson, Blue Cross; and Dr. Ernest Saward, University of Rochester, Director of Ambulatory Care, describing a new prepaid facility in the Rochester area. Persons interested in attending the seminar should request registration forms from: H. Dickson McKenna, Executive Director, New York State Association of Architects/AIA, 441 Lexington Avenue, New York, N. Y. 10017. Telephone (212) 697-8866. Fee: $25.00. Checks should be made payable to NYSAA/AIA.

EDITOR'S NOTE:

Five previous Seminars were: (all held in Albany)

July 1971 – Programs For Capital Financing Of Hospital Facilities

May 1971 – Planning Intensive And Coronary Care Units

April 1970 – Health Care

Nov. 1969 – Hospital Supplies & Materials Handling
(Mechanical and Manual Methods)

April 1969 – Hospital Regulations

New York Chapter

The American Institute of Architects

# Directory of Health Facilities

Prepared by

The Hospitals and Health Committee

JANUARY 1972


## ACKNOWLEDGMENTS

The Hospitals and Health Committee of the New York Chapter, AIA, is deeply indebted to the staff of the Health and Hospital Planning Council of Southern New York, Inc. for its efforts in researching, collecting, editing, and transcribing the information contained in this Directory. Thanks are also accorded to those members of the AIA who have contributed their knowledge of the specific projects.


## INTRODUCTION

This Directory is offered to visiting architects, hospital administrators, and others interested in the planning and operation of health care facilities. As a guide to those services of particular interest to the user, each facility is described through its features of special interest.

In the compilation of the Directory, a calculated effort was made to minimize value judgements about each project and to include as many facilities as possible for the information of the user. Future issues of the Directory will be used to expand the number of institutions listed.

■ **BEEKMAN-DOWNTOWN HOSPITAL**
170 William Street, New York, New York
Voluntary
Arthur W. J. Beeney, Administrator
Telephone: (212) BE 3-5300
Architect: Skidmore, Owings & Merrill
Completed: 1971
Features:
1. Interior Design and Planning of Radial Intensive Care and Coronary Care Units
2. Emergency Trauma Unit
3. Example of Expansion of Urban Hospital while in operation

■ **BENEDICTINE HOSPITAL**
105 Mary's Avenue, Kingston, New York
Voluntary
Sister Mary Charles McCarthy, Adminstrator
Telephone: (914) 338-2500
Architect: Ferrenz & Taylor
Completed: 1967
Features: Phasing with new addition designed for future demolition of adjacent non-conforming structures, with no interruption of hospital functions

■ **BLYTHEDALE CHILDREN'S HOSPITAL**
95 Bradhurst Avenue, Valhalla, New York
Voluntary
Robert Stone, Administrator
Telephone: (914) LY 2-7555
Architect: Viola, Bernhard & Phillips
Completed: 1968
Features:
1. Site orientation with respect to a bountiful site
2. Relation of physical facilities to unique program

■ **BRONX-STATE HOSPITAL**
Bronx Children's Psychiatric Hospital
Hutchinson River Pkwy. & Westchester Ave., Bronx, New York
Dr. Richard Feinberg, Administrator
Telephone: (212) 931-0600
Architect: Max Urbahn
Completed: 1969
Features: Example of children's psychiatric hospital with non-institutional character and residential scale

■ **BROOKDALE HOSPITAL CENTER**
Linden Blvd. at Brookdale Plaza, Brooklyn, New York
Voluntary
Morrell Goldberg, Administrator
Telephone: (212) HY 5-6800
Architect: Katz, Waisman, Weber & Strauss
Completed: 1971
Features:
1. Coronary Care Unit
2. Laboratories with completely automated chemical laboratory
3. Nursing Unit with large areas well arranged and Intensive Care Units on same floor as Surgical Suite
4. Multi-phasic Screen Center (closed for lack of funds)
5. Surgical Suite with good separation of traffic; sterile areas distinct from soiled; Operating Rooms around clean work area; circulation peripheral and utilities on floor above
6. Outpatient Department with non-institutional character where design contributes to personal relationship between doctors and patients

■ **CENTRAL ISLIP STATE HOSPITAL**
Sagamore Children's Center, Melville, L.I., New York
New York State Hospital
Dr. Mary B. Hagamen, Administrator
Telephone: (516) 427-3355
Architect: Norval White
Completed: 1969
Feature: Suburban children's psychiatric hospital with non-institutional character

■ **COMMUNITY HOSPITAL AT GLEN COVE**
Glen Cove, Long Island, New York
Voluntary
Lawrence E. Dickovick, Jr., Administrator
Telephone: (516) OR 6-5000
Architect: Westermann-Miller Associates
Completed: 1970
Features:
1. Construction with exposed concrete and long span high strength steel construction
2. Mechanical Services with intricate integration of heating, ventilating and air-conditioning within low floor to floor heights to align with existing floors
3. Pediatric Nursing Unit (25 beds)

■ **FRENCH & POLYCLINIC MEDICAL SCHOOL & HEALTH CENTER**
New York Polyclinic Hospital Division
345 West 50th Street, New York, New York 10019
Voluntary
Elliot J. Simon, Administrator
Telephone: (212) CO 5-8000
Architect: Norman Rosenfeld
Completed: 1970
Feature: Cardiac Care Unit with 5 beds; complete monitoring system, example of new service introduced into old existing building (by renovation)

■ **HEALTH INSURANCE PLAN OF GREATER NEW YORK**
H.I.P. Automated Multiphasic Health Testing Center
84 Fifth Avenue, New York, New York 10011
Voluntary
Philip Schrefer, Administrator
Telephone: (212) 691-0950
Architect: Horowitz & Chun
Completed: 1971
Feature: 1. Multiphasic Testing Facilities

■ **HEBREW HOME FOR THE AGED**
Riverdale, New York
Voluntary
Jacob Reingold, Administrator
Telephone: (212) 549-8700
Architect: Gruzen Partners
Completed: 1966
Features:
1. Site with solution of scale and aesthetics in beautiful countrified setting
2. Nursing Unit Planning
3. Physical facilities reflect full program development

■ **HILLSIDE HOSPITAL**
263rd St. & 76th Avenue, Glen Oaks, Queens
Voluntary
Samuel Davis, Administrator
Telephone: (212) FI 3-7800
Architect: Louis Allen Abramson York & Sawyer
Completed: 1940, 1957, 1965
Feature: Psychiatric Hospital with non-institutional character in pavilion type design

■ **ISABELLA HOME NURSING HOME**
501 West 190th Street, New York, New York
Voluntary
Lawrence E. Larson, Administrator
Telephone:
Architect: Weiss, Whelan, Edelbaum, Webster
Completed: 1972 (scheduled)
Features:
1. Nursing Home and Health Related Facility combined in single building
2. Self care units
3. Wide range of supporting services
4. Example of urban nursing home

■ **JEWISH HOME & HOSPITAL FOR THE AGED**
Greenwald Pavilion
121 West 106th Street, New York, New York
Voluntary
Mitchell Waife, Administrator
Telephone: (212) MO 6-2000
Architect: Weiss & Whelan
Completed: 1967
Features:
1. Site with urban solution includes large interior garden and roof terraces
2. Wide range of supporting services

■ **LONG ISLAND JEWISH MEDICAL CENTER**
270-05 76th Avenue, New Hyde Park, New York
Voluntary
Dr. Robert K. Match, Administrator
Telephone: (516) 437-6700
Architect: Louis Allen Abramson, York & Sawyer
Completed: 1954
Features:
1. Surgical Suite with central work core; distinct circulation patterns; and early example of two-corridor plan (1954 and 1971)
2. Typical Nursing Unit is example of early double corridor scheme (1954 and 1971)
3. Laboratories (completed 1971)
4. Radiology with Nuclear Medicine is pioneer project (1954 and 1971)
5. Emergency (1971)

■ **MAIMONIDES MEDICAL CENTER**
4802 Tenth Avenue, Brooklyn, New York 11219
Voluntary
Irving J. Cohen, M.D., Administrator
Telephone: (212) UL 3-1200
Architect: Kahn & Jacobs
Completed: 1971
Features:
1. Surgical Suite with zoning of particular interest
2. Radiology with circulation of particular interest

■ **MAIMONIDES MEDICAL CENTER**
Maimonides Community Mental Health Center
4802 Tenth Avenue, Brooklyn, New York 11219
Voluntary
Dr. Montague Ullman, Administrator
Telephone: (212) 854-7373
Architect: —
Features:
1. Community Mental Health Center with non-institutional interior treatment
2. Facilities planned for use by all community groups

■ **MARTIN LUTHER KING HEALTH CENTER**
3rd Avenue & 167th Street, New York, New York
Voluntary
Bernard Simon, Administrator
Telephone: (212) 992-9100
Architect: Schuman, Lichtenstein & Claman
Completed: 1968
Features:
1. Early example of Neighborhood Family Care Center
2. Renovation of warehouse
3. Outpatient program with community services as forerunner to Family Care Units

■ **MEMORIAL HOSPITAL FOR CANCER & ALLIED DISEASES**
Firestone Radiation Thereapy Center
444 East 68th Street, New York, New York
Voluntary
Glenn A. Wesselmann, Administrator
Telephone: (212) TR 9-3000
Completed: 1966
Features: Radiology with Diagnostic and Therapy, including three cobalt units, linear accelerator, and betatron device

(continued)

■ MEMORIAL HOSPITAL FOR CANCER & ALLIED DISEASES

Alfred Jacobsen Outpatient Building
444 East 68th Street, New York, New York
Voluntary
Glenn A. Wesselmann, Administrator
Telephone: (212) TR 9-3000
Architect: Rogers, Butler & Burgun
Completed: 1969
Features: Outpatient Department in Ambulatory Care Building that is extensive in range and facilities

■ MEMORIAL HOSPITAL FOR CANCER & ALLIED DISEASES

Nurses Residence-Sloan House
1233 York Avenue, New York, New York
Voluntary
Glenn A. Wesselmann, Administrator
Telephone: (212) TR9-3000
Architect: Harrison & Abramovitz
Completed: 1962
Features: Staff Residence-Nurses Residence Studio singles and bedroom apartments; 150 units

■ MERCY HOSPITAL

565 Abbott Road, Buffalo, New York
Voluntary
Sister Mary Annunciata, Administrator
Telephone: (716) 826-7000
Architect: Mortimer Murphy
Completed: 1970
Features:
1. Central Sterile Supply with automated monorail distribution system
2. Food Service with convenience food distributed by monorail

■ MONTEFIORE HOSPITAL & MEDICAL CENTER

Moses Lab Research Building
111 East 210th Street, Bronx, New York
Voluntary
Martin Cherkasky, M.D., Administrator
Telephone: (212) 920-4001
Architect: Philip Johnson
Completed: 1966
Feature: Building design

■ MONTEFIORE HOSPITAL & MEDICAL CENTER

Diagnostic & Treatment Center
210th St. & Bainbridge Avenue, Bronx, New York
Voluntary
Dr. Martin Cherkasky, Administrator
Telephone: (212) 920-4001
Architect: Westermann-Miller Associates
Completed: 1970
Features:
1. Emphasis on Interior treatment
2. Pharmacy with conveyer belt order filling
3. Outpatient Department with extensive and individual specialty clinics, non-institutional character with cluster plan

■ MORRISANIA CITY HOSPITAL

Morrisania Neighborhood Family Care Center
168th St. & Walton Avenue, Bronx, New York
New York City Hospital
Symuel H. Smith, Administrator
Telephone: (212) 960-2531
Architect: Armond Bartos
Completed: 1972 (scheduled)
Feature: Example of neighborhood outpatient center

■ MOUNT SINAI MEDICAL CENTER

Mount Sinai School of Medicine
Fifth Ave. & 100th Street, New York, New York 10029

Voluntary
Dr. George James, Administrator
Telephone: (212) TR 6-1000
Architect: Skidmore, Owings & Merrill
Completed: 1974 (scheduled)
Features:
1. Tight Urban Site with Intricate Phasing
2. Surgical Suite with extensive in scope
3. Radiology with extensive Diagnostic and Therapeutic Suite
4. Outpatient Department extensive
5. Automated Distribution of Supplies
6. Hyperbaric Chamber
7. School of Medicine with renovations of garage for basic sciences program Audio-Visual techniques and current teaching methods

■ NEW ROCHELLE HOSPITAL MEDICAL CENTER

Howe Avenue Nursing Home
(Extended Care Facility)
Howe Avenue
New Rochelle, New York
Voluntary
Mr. Donald Baker, Administrator
Telephone: (914) 632-5000
Architect: Frost Associates
Completed: 1971
Features:
1. Site as part of New Rochelle Hospital Complex with restriction in size and sharp grade
2. Example of Extended Care Facility with its necessary components

■ NEW YORK UNIVERSITY MEDICAL CENTER UNIVERSITY HOSPITAL

First Avenue & 34th Street, New York, New York
Voluntary
Irwin G. Wilmot, Administrator
Telephone: (212) OR 9-3200
Architect: Skidmore, Owings & Merrill
Completed: 1969
Features:
1. Laboratories with extensive research facilities
2. Surgical Suite that is extensive including open heart surgery program
3. Diagnostic Radiology Suite

■ **NEW YORK UNIVERSITY MEDICAL CENTER**
Institute of Rehabilitation Medicine
400 East 34th Street, New York, New York
Voluntary
George J. DeGraff, Administrator
Telephone: (212) OR 9-3200
Architect: Skidmore, Owings & Merrill
Completed: 1969
Feature:
1. Rehabilitation Medicine Facilities
2. Ambulatory Care
3. Hyperbaric Chamber

■ **NEW YORK HOSPITAL**
Payson House
York Avenue & 79th Street, New York, New York
Voluntary
John F. Doyle, Resident Manager
Telephone: (212) 879-9000
Architect: Frost Associates
Completed: 1967
Feature: Staff Residence (465 Units)

■ **NORTH SHORE HOSPITAL**
Extended Care Facility
Manhasset, Long Island, New York
Voluntary
Dennis F. Buckley, Administrator
Telephone: (516) MA 7-5000
Architect: Ferrenz & Taylor
Completed: 1970
Features:
1. Site where unit is attached to main hospital building, with connecting passage on each floor and successful treatment and use of site
2. Physical Therapy with heated therapy pool and extensive facilities
3. Occupational Therapy on each floor (decentralized)
4. Extended care beds (122 beds in three nursing unit)

■ **PRESBYTERIAN HOSPITAL**
622 West 168 Street, New York, New York
Voluntary
Alvin J. Binkert, Administrator
Telephone: (212) 579-2500
Architect: Rogers, Butler & Burgun
Completed: 1966
Features:
1. Radiation Therapy Complex with Cobalt Unit
2. Intensive Care Unit
3. Babies Hospital

■ **PRESBYTERIAN HOSPITAL**
Doctors Office Building
161 Fort Washington Avenue, New York, New York
Voluntary
Alvin J. Binkert, Administrator
Telephone: (212) 579-2500
Architect: Rogers, Butler & Burgun
Completed: 1968
Feature: Medical Staff Office Complex
Private Practice connected via tunnel to Medical Center

■ **ROCKEFELLER UNIVERSITY HOSPITAL**
66th Street & York Avenue, New York, New York
Voluntary
Dr. Maclyn McCarthy, Administrator
Telephone: (212) LE 5-9000
Architect: Harrison & Abromovitz
Completed: 1957
Feature: Hemispherical auditorium with 500 seat capacity, extensive audio-visual facilities including closed circuit television and video tape projectors

■ **SAMARITAN HOSPITAL**
Peoples & Burdett Avenue, Troy, New York 12180
Voluntary
Albert B. Osborne, Jr., Administrator
Telephone: (518) 274-3000
Architect: The Perkins & Will Partnership
Completed: 1972 (scheduled)
Features:
1. Nursing unit design with all corner 2-bed room arrangement
2. Intensive and Coronary Care Unit Design with shared and swing facilities
3. Community Mental Health Center as part of a general hospital, including in-patient, out-patient and day-care programs

■ **ST. FRANCIS NEIGHBORHOOD FAMILY CARE CENTER**
142nd Street & St. Anns Avenue, Bronx, New York
Voluntary
Administrator: Unassigned
Architect: Frost Associates
Completed: 1972 (scheduled)
Feature: Example of Neighborhood out-patient Center

■ **ST. JOHN'S RIVERSIDE HOSPITAL**
967 North Broadway, Yonkers, New York
Voluntary
Irving T. Howorth, Administrator
Telephone: (914) 963-3535
Completed: 1964
Features:
1. Site and its utilization
2. Example of complete replacement near New York City

■ **ST. JOHN'S SMITHTOWN HOSPITAL**
Route 25S, Smithtown, L.I., New York
Voluntary
John P. Rugh, Administrator
Telephone: (516) 360-2111
Architect: Frost Associates
Completed: 1969
Features:
1. Site with large rural atmosphere
2. Construction with concrete frame and precast concrete wall construction
3. Circulation with Central Sterile Supply Surgical Suite, and Emergency related

■ **SLOAN KETTERINE INSTITUTE FOR CANCER RESEARCH**

New Research Building
444 East 68th Street, New York, New York
Completed: 1964
Remodelled Research Building. Remodelled: 1968

■ **SUSAN GREENWALL NURSING HOME**

Greenwall Pavillion
2545 University Avenue, Bronx, New York
Voluntary
Administrator: Unassigned
Telephone:
Architect: Weiss, Whelan, Edelbaum, Webster
Completed: 1972 (scheduled)
Features: 1. Nursing floors arrangement and spaciousness
2. Extensive supporting services

■ **UNITED HOSPITAL**

406 Boston Post Road, Port Chester, New York
Voluntary
Richard Stolnacke, Administrator
Telephone: (914) WE 9-7000
Architect: Rogers, Butler & Burgun
Completed: 1967
Features: 1. Emergency entrance affords easy excess with two waiting rooms separating acute from mild injuries and central nursing station.
2. Intensive Care Unit with well isolated cubicles with toilets and basins; central nursing station and family waiting area.

■ **UNIVERSITY HOSPITAL** See New York University Medical Center

# ROSTER MEMBERS - 1971-1972

## Hospitals and Health Committees

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*Blumenkranz & Bernhard*

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*Lenox Hill Hospital*

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*Robert H. Chapman Assoc.*

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*Haines, Lundberg & Waehler*

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*Rogers, Butler & Burgun*

**Cohen, Martin H.**
*Skidmore, Owings & Merrill*

**Copley, Nancy (Miss)**
*Copley, Strauss*

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*Health & Mental Hygiene Improvement Corp.*

**Deskey, Michael D.**
*Harrison & Abramovitz*

**Dunkley, Leon L.**
*NYCHHC - Health SPACE*

**Ehrlich, Isaiah**
*Rogers, Butler & Burgun*

**Eliseo, Frank**
*Health & Mental Hygiene Facil. Improvement Corp.*

**Ellenbogen, Saul**
*Hospital Review & Planning Council of Southern N. Y.*

**Foster, Harold**
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*Armand Bartos & Associates*

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*N. Y. S. Dept. of Health*

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*Abraham W. Geller & Assoc.*

**Gibson, G. Darcy**
*Health & Mental Hygiene Facil. Improvement Corp.*

**Ginsberg, David L.**
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**Goldsamt, Alan B.**
*Frost Associates*

**Kupper, Thomas J.**
*NYCHHC - Health SPACE*

**Kushner, William**
*Health & Mental Hygiene Facil. Improvement Corp.*

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*Metcalf and Associates*

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*Juster, Brosmith, Levine*

**Lewis, Jane H. (Mrs.)**
*Regional Hospital Review & Planning Council of N. E.*

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*Westermann-Miller Assoc.*

**Mennen, Irving A.**
*N. Y. S. Dept. of Health*

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*N. Y. S. Housing Finance Agency*

**Neufeld, Joseph**
*Joseph Neufeld*

**O'Brien, John L.**
*John L. O'Brien, Jr. - Architect*

**Pepper, Eleanor**
*The Office of Eleanor Pepper*

**Pancaldo, Carl E.**
*Associate Architects*

**Parrette, Allen C.**
*Eggers Partnership*

**Prainito, Bernard**
*Max O. Urbahn*

**Price, Thomas H.**
*Eggers Partnership*

**Pucillo, Emilio M.**
*U. S. Public Health Service*

**Ritchin, Kenneth**
*Mount Sinai Hospital*

**Rosenfeld, Norman**
*Norman Rosenfeld*

**Shein, Joseph**
*Russo & Sonder*

**Shilowitz, Stephen**
*Stephen Shilowitz*

**Shoesmith, David B.**
*David B. Shoesmith*

**Smith, Jack W.**
*Caudill, Rowlett, Scott*

**Sonder, Richard**
*Russo & Sonder*

**Sput, Murray**
*Gruzen & Partners*

**Strauss, Peter L.**
*Perkins & Will*

**Strunk, Earl H.**
*Vogel & Strunk*

**Taylor, Gray**
*SMS Partnership*

**Viola, Louis V.**
*Brookdale Hospital*

**Whelan, Donald V.**
*Weiss, Whelan, Edelbaum, Webster*

**Wolfe, Clifford E.**
*Kiff, Voss & Franklin*

# NEW YORK CHAPTER/AMERICAN INSTITUTE OF ARCHITECTS HOSPITALS AND HEALTH COMMITTEE

## 1953-56

In the period after World War II, the backlog of need for health facilities, combined with Federal assistance in the form of Hill-Burton funds, spurred the volume of design and construction of hospitals. Architects whose offices were designing these facilities felt the need to exchange information regarding this highly specialized building type. In 1953, informal lunch meetings were started for this purpose. Soon these were incorporated as part of the New York Chapter's technical committee program. During 1954, interest grew and Alonzo Clark was appointed Chairman to arrange round-table meetings on a monthly schedule. Five members of the Chapter participated in these early programs. By 1955, Isaiah Ehrlich had taken charge of field trips which grew in importance as an activity. Facilities were visited on Saturday mornings, with a review of the planning held at a luncheon at the host hospital. The regular luncheon meetings under the guidance of Mary Worthen grew in importance, attracting new members. In order to expand the participation of employees of various offices, the meetings were moved to the late afternoon, and later expanded into a training course in hospital design. As an experiment, a dinner meeting was held open to all Chapter members to hear opposing views on hospital planning by Dr. Basil Maclean, then Commissioner of Hospitals, and Dr. E. M. Bluestone, a prominent hospital administrator. By 1956, smaller dinner meetings were started at the Harvard Club to focus more in-depth conversation on limited subjects. With the growth of activity, the group was reorganized into the Committee on Hospitals and Health, and on March 6, 1956 the New York Chapter Executive Committee made the action formal, paralleling the creation of the national committee.

## 1956-57

### Isaiah Ehrlich, Chairman

All activities grew in intensity and participation expanded under Isaiah Ehrlich, the first Chairman. A Research subcommittee was added, under Dan Jensen, to gather ideas for research programs. Conferences were held with Dr. Louis Block, Chief of Research Grants Division of the U. S. Public Health Service to find ways to implement the program. Field trips, dinner meetings, and afternoon conferences were continued.

## 1957-59

### William J. Taylor, Chairman

Efforts were continued to activate the research program under Isadore Rosenfield. In March 1958, a grant application was filed with the U. S. Public Health Service; it was subsequently disapproved. In May 1959, a Chapter-wide meeting was held on "Trends in American Hospital Construction", with Dr. Jack Halderman, Asst. Surgeon General, USPHS, and Dr. John J. Bourke, Executive Director, New York State Joint Hospital Survey and Planning Commission, as speakers.

## 1959-61

### James Sonder, Chairman

With Alonzo Clark as Vice Chairman, and Harold Olsen heading the Research subcommittee, activities were directed towards a defined area of study - the Operating Suite. With Robert H. Jacobs as Director of Research, a new program was written, and in September 1959 a second grant application was made to the U. S. Public Health Service. By June 1960, it was approved and the project started. In 1960, the Committee expanded its membership and added a subcommittee on Hospital Code and Licensing Regulations. These activities catalogued requirements of member agencies and initiated meetings with officials of the New York City Department of Health, and the New York City Department of Hospitals with the purpose of improving code requirements. Other subcommittee chairmen included: Isaiah Ehrlich, Robert M. Bradury, J. Armand Burgun, and Zachary Rosenfield. Two field trips and nine instructional conferences were held in addition to the ten regular meetings.

## 1961-63

### Alonzo W. Clark, III, Chairman

With J. Armand Burgun as Vice Chairman, and Robert M. Bradbury as Secretary, the Committee expanded and strengthened its goals of training, education, research, and medical facilities planning. The Research subcommittee, chaired by Zachary Rosenfield, completed the U. S. Public Health Service sponsored project. Robert H. Jacobs, the principal researcher attracted national attention for the work, including articles in the A.I.A. and AHA Journals. The Public Agencies subcommittee, under J. Armand Burgun, continued activities of code review and regulatory agency participation, while Publications, chaired by Isaiah Ehrlich, arranged for the coverage given to the research work and other Committee activities. Six special meetings were given by Allen Parrette's group, along with five educational and training sessions, and three field trips by Howard Juster's subcommittee. Joseph Weiss initiated activities of coordination with the National Committee on the Aging.

# Recent History Of Activities

**1963-65**

**J. Armand Burgun, Chairman**

The Committee had grown to 21 members, with Howard H. Juster as Vice Chairman, and Richard Sonder, and later Robert M. Bradbury, as secretaries. The highlight of the year 1964 was the National Conference on Designing for Asepsis, jointly sponsored with the U. S. Public Health Service, the Hospital Review and Planning Council of Southern New York, Inc., and the National Committee on Hospital Architecture. The conference attracted 150 persons. Regular activities during each year included ten committee meetings, six dinner meetings, three instructional sessions, and two tours. Public agency and research activities continued. Subcommittee chairmen were Allen C. Parrette, Louis V. Viola, Richard Sonder, Zachary Rosenfield, Isaiah Ehrlich, Robert H. Jacobs, and Howard H. Juster. The Committee joined with the New York Academy of Sciences and the American Association of Medical Colleges in sponsoring a Conference on Medical Schools and Teaching Hospitals, with an attendance of 400.

**1965-67**

**Howard H. Juster, Chairman**

With Richard Miller as Vice Chairman, and David L. Ginsberg, Secretary, the Committee's activities continued on all fronts. A two-day national conference on computers was held, along with a wide range of educational and training special meetings, and field trips. The highlights of this period were the formulation of the concept for the Health Facilities Laboratory and the initiation of hospital planning and design educational courses. The HFL proposal study has continued and approaches completion in the present program.

**1967-69**

**Richard A. Miller, Chairman**

Now a group of 34 members with Richard Sonder, Vice Chairman, and Carl E. Pancaldo, Secretary, the Committee held a conference on Comprehensive Health Facilities in New York attended by 150 people. The first Basic Hospital and Planning Course was held with the cooperation of the Columbia University School of Public Health and Administrative Medicine. The course was directed by Joseph Blumenkranz and had 35 enrollees. Yearly programs included ten luncheon meetings, five field trips, five instructional conferences, and six special meetings. The Health Facilities Laboratory proposal was developed into a national task force under the jurisdiction of the Public Affairs Commission of the National A.I.A. with Howard H. Juster as representative.

**1969-71**

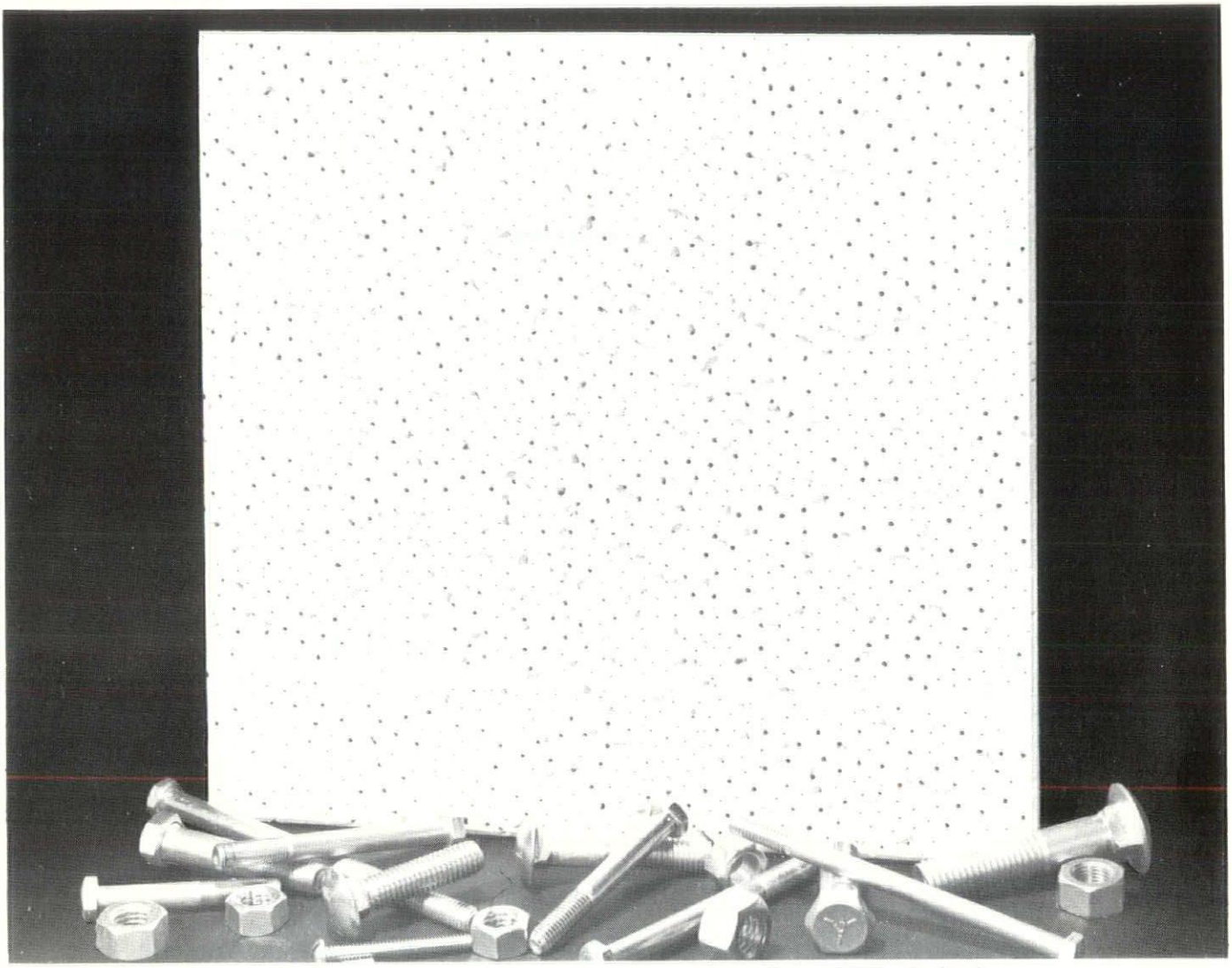
**Richard Sonder, Chairman**

The Committee grew to 40 members and an expanded subcommittee organization, including Morris Abraham, David Ginsberg, and Clifford Wolfe as Vice Chairmen, and Joseph Shein, as Secretary. An international conference was held on Research in Health Facilities with 150 persons present. The Basic Hospital educational course was repeated, and the Roger MacPherson Seminar in Hospital Planning, an advanced lecture series, was held. A Handbook of Regulatory Agency Procedure was prepared by Jane Lewis and issued to all members. Field trips were expanded geographically to include one to Washington, D. C. and Baltimore, and one to Hamilton, Ontario, Canada. A total of 25 Committee meetings, 40 subcommittee sessions, and 32 educational course sessions were held. By 1971, the Committee had further grown to 45 and reached its present organizational pattern.

**1971 to Present**

**David L. Ginsberg, Chairman**

The present Committee is organized in three sections, with a total of 55 members, plus others invited to participate as guests. Morris Abraham is Vice Chairman in charge of the Policy Section; Clifford Wolfe, Vice Chairman for the Activity Section; Joseph Shein, Vice Chairman for the Projects Section; and Peter Strauss, Secretary of the Committee. Programs in the Policy Section include: Professional Practice under Herbert Bienstock, which has prepared comments on the New York City All-Agency Contract, and the New York State Health Department revisions to AIA-B131; Public Agencies, under Richard Clark, which has commented on the New York City Plan and newly issued codes; and Public Information, under Larry Mason, which will publish the Health Facility Directory, a Health Facility Cost Study, a report on the Annual Conference, and a Guide to Health Information Receivers. The Activity Section will include approximately eight field trips, planned by Allen C. Parrette; four afternoon instructional sessions and ten luncheon programs under Murray Sput and an expanded educational program chaired by Isaiah Ehrlich. The educational programs will include the Hospital Basic Course, under course instructor Clifford Wolfe, with Pratt Institute, and an Advanced Course with the University of the City of New York this fall. Project activities include study programs related to the Health Facility Directory by Saul Ellenbogen; the Comprehensive Health Planning Agency liaison with Richard Sonder; library study project by Norman Rosenfeld; Health Facility Costs by Saul Ellenbogen; the Health Facility Research Task Force with Howard Juster; Exhibits by Alonzo Clark; Industrialized Building by Abraham Geller; the Committee History by Carl Pancaldo; a liaison study with hospital consultants under Isaiah Ehrlich; and a conference on Life Safety in Health Facilities in October, attended by 150 and chaired by Thomas J. Kupper.



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# Structuring Security In A Hospital

By Norman Jaspan

*Norman Jaspan is President of Norman Jaspan Associates, Inc., Management Engineers, and its fact-finding division, Investigations, Inc. Established more than 40 years ago, these firms operate internationally. They combine fact-finding procedures with management consulting functions and specialize in shortage control, methods and systems evaluations, and material handling procedures.*

*Clients include more than 200 companies listed on the Stock Exchange -- in such diversified fields as heavy industry, soft goods manufacturing, airlines, hotels and hospitals. This company also serves approximately one out of every three major retailers.*

*Articles by Norman Jaspan appear frequently in leading magazines and trade publications. He has participated in several panel discussion programs on television, lectured at various universities, and was a member of President Eisenhower's committee on Technical and Distribution Research for the Benefit of Small Business.*

*Mr. Jaspan's book, The Thief in the White Collar, published by J. B. Lippincott Company, is a national best seller, and his new book, Mind Your Own Business, will be published shortly.*

The principle that it is cheaper and more effective to treat a malady before it becomes inoperable is as true in the field of hospital administration as it is in patient care. Preventive management techniques scientifically applied to control internal dishonesty, exorbitant waste and to provide safety can slash hospital operating expenses and reduce patient care cost substantially.

The capital investment of all U.S. hospitals today is in excess of 30 billion dollars. It is the third largest industry, surpassing the investment in automobiles, railroads, and even telephone communications.

The responsibility of the hospital administrator is a formidable one, indeed. The operation of a hospital is not only big business, but a complex of many big businesses. The administration must contend with the problems of building maintenance; a pharmacy, hotel, laundry, restaurant, purchasing department, research and educational institution.

For these reasons, hospital complexes are one of the most challenging types of construction for which to design suitable security safeguards. From a cost and effectiveness viewpoint, there is no better time for developing a comprehensive program than at the blueprint stage. If management waits until after the building is erected, expanded or renovated additional and substantial expenses will be incurred in order to belatedly install safeguards which often are poor compromises.

There are five areas meriting attention:

1. Procedures governing the flow of food, drugs, supplies and equipment, from time of purchase until their receipt, as well as their storage and issuance.
2. Total hospital site. The problems of perimeter security, visitors, and pedestrian and vehicular traffic; the safety of patients, visitors, and employees.
3. Accountability of cash payments, accounts receivable and other valuables.
4. Protecting medical records and other confidential information.
5. Guard coverage and technology necessary for them to perform optimally.

### Hospital Security Defined

An effective hospital security program will aim at achieving the highest attainable level of safety, protection of supplies and equipment, as well as the persons and belongings of patients and employees, without adversely affecting efficiency and control considerations. Of course, the practicality of all physical and procedural regulations has to be measured by their enforcibility. Any control measure and operating rules which require an anormous supervisory effort to enforce, or incur deep visitor and patient resentment, or high employee turnover are bound to be ineffective.

### Scope of Program

The security program has to aim at curtailment of fraudulent diversion. This includes two major categories of theft: (a) pilferage by employees, patients, visitors on the one hand, and (b) large scale diversion through collusive effort such as between drivers and receivers; maintenance men and outside contractors; laundry workers and outsiders; professional personnel and suppliers; to name but a few examples.

(continued)

# HOPE'S WEATHERSTRIPPED STEEL WINDOWS

Photo by M. E. Warren

St. Martin's Home for the Aged — conducted by the Little Sisters of the Poor, Baltimore County, Maryland
*Architects:* Gaudreau Architects, Baltimore, Maryland • *General Contractors:* R. S. Noonan Company, York, Pennsylvania

The concept of "bringing in the outdoors" guided the architect in the design of this handsome and very livable structure. Compatability with the religious and daily living functions of the aged and a type of ventilation and hardware suitable for the occupants determined the architectural design requirements of the windows. Consideration of these factors prompted the architect to specify Hope's Heavy Intermediate Weatherstripped Steel Windows with clear lights above and hopper vents at sill. Through the large upper fixed lights, the outside scenery is pleasantly visible to both the elderly and the staff during the course of each day's routine. To obtain the desired color and the durability of a factory-applied finish, Hope's Ultra-Coat was specified. This process includes cleaning by shot blasting prior to fabrication; zinc phosphate treatment in a continuous five-stage process; a prime coat of oven-baked epoxy alkyd; and a spray finish coat of acrylic enamel applied in an automated electrostatic process and oven baked. Hope's Weatherstripped Steel Windows with continuous Neoprene weatherstripping applied in integrally rolled grooves combine the strength and rigidity found only in steel and have an air infiltration rate comparable with weatherstripped windows of any type. Hope's engineers worked closely with the architect from the initial design stage, and erection by Hope's own crews eliminated the problem of divided responsibility.

## HOPE'S WINDOWS

*Jamestown, New York 14701*

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## HOSPITAL SECURITY — continued

A security program must be based on an awareness of the relative risks and potential losses in both types of diversion.

### The Uniqueness of Hospital Security

Pedestrian traffic through a hospital allows very little curtailment. It is possible to prevent unauthorized traffic through selective areas such as the pharmacy, laboratories, central supply, or medical records library. It is very difficult to curtail traffic through the corridors where patients, visitors, doctors, contractors and employees of all levels, are virtually indistinguishable. Consequently, the primary aim is to limit the exposure of supplies and equipment, whether in storage, transit or use.

The question of exposure of items is directly related to the problem of space utilization. The question of transit security is integral to vertical and horizontal transportation considerations, including material handling procedures, the type of conveyances used, and the required corridor dimensions and elevator facilities.

### The Receiving Dock

The most vulnerable area for large scale diversion is the receiving dock. The best security is to provide a receiving dock exclusively for the use of receiving supplies and equipment.

Space and budgets permitting, there should be a separate dock for outgoing soiled and incoming fresh linen (unless the hospital has its own laundry within the complex.) A separate dock for trash removal, should also be provided, both for security as well as hygienic considerations. There should also be a separate loading area for the morgue.

The receiving dock should be so located so as to require no pedestrian traffic across the dock nor in the immediate vicinity. The official employee exit ideally should be at the opposite end of the hospital so that the chance for exiting employees to come in contact with supplies and equipment in the process of being received is sharply curtailed.

Externally, it is most advisable to place the receiving dock in an area which can be fenced off from the nearest approach road. The basic security approach would be to have the gate and fence closed and locked whenever the receiving dock is unattended. Depending on traffic patterns in some hospitals this may call for a remote control gate; in others, a manually operated gate may suffice.

Internally, provision must be made to permit reliable dual accountability for those supplies which should be identified, verified, and perhaps weighed on the dock, and again verified and counted upon arrival in storage. Since space and flow considerations are of paramount importance here, it is inopportune to consider these matters after the architectural drawings are approved and construction begun.

At the linen dock, it is essential to prevent linen drivers from access to other areas of the hospital when they pick up soiled or deliver fresh linen. These pick ups are often performed in the very early morning when payroll considerations would make it inadvisable to staff the linen dock. Therefore, the linen dock must be sealed off through reliable lockup arrangements from the rest of the hospital, or approaches to the linen dock must be restricted by a gate controlled by a hospital employee who would supervise the linen loading and unloading operation. The importance of such measures is underscored by the fact that the stolen supplies and equipment are often concealed in soiled linen containers.

A separate trash removal dock should be also provided with similar precautions to prevent unsupervised access to hospital assets during the trash loading operation.

### The Employee Exit

The curtailment of employee pilferage can be ideally effected by requiring all employees to enter and depart from one exit. In hospitals which consist of one main building and only few auxiliary buildings this goal is attainable.

Channeling the flow of employee traffic through the designated exit, in spite of the availability of numerous fire exits and visitors lobbies, can be achieved by placing time clocks and locker rooms in strategic locations. Another consideration is the location of the employee parking lot to permit easy access during inclement weather.

### Linen Security

In most urban communities linen is usually the most vulnerable supply item, it is easily disposable at a profit and it is a tempting target for pilferage for employees, patients, and visitors. Moreover, linen on the nursing floors is a supply item requiring the most frequent access by nurses and aides. Great care must therefore be taken in the relative location of nursing stations and other patient care areas to the location of linen closets or alcoves where linen carts are to be stored.

Similarly, regional storage rooms will have to be subject to specialized protection arrangements. If such areas are in close proximity to heavily trafficked corridors or, conceivably, through accessible windows or fire exits, protection by some form of electronic intrusion alarm equipment will have to be considered.

If the hospital maintains its own laundry within its complex special intrusion protection may have to be designed to protect the laundry during periods when there is no one in attendance.

### Storage Areas

Space availability and fire laws permitting it will be advantageous to design areas such as central surgical supply, general storage or maintenance supply and tool crib areas, in such a way that there is no direct exit through fire doors, nor any connection to the outside through windows. If this is not possible, consideration should be given to some form of electronic intrusion alarm protection.

Such arrangements should be taken into consideration when the grand master and sub master key setups are designed.

### Food Products

Failure to properly control the handling and storage of fresh meats and poultry can be very costly. It is vital, therefore, for the location of meat freezers and coolers, and storage areas for canned meats and poultry, to be carefully selected and that these areas be provided with suitable lockup devices during the planning phase.

Canned staple foods are second in priority from a security point of view. Reliable lockup hardware as well as possible intrusion protection by electronic means, depending upon the location of the food storage area, would have to be considered.

Lockup of dairy and produce freezers and coolers usually does not have to be quite as rigid as the system protecting the meat storage areas.

(continued)

### Pharmacy

Lockup requirements for narcotics and hypnotic drugs are clearly stipulated by Federal and State laws. As a general rule it is best to design the central pharmacy or any regional pharmacy which may serve the clinics in such a way as to limit access to pharmacists and their assistants only. This is often accomplished by equipping pharmacies with Dutch type doors or ledge equipped windows through which all negotiations between pharmacists and nursing personnel can take place.

### Emergency Room and Out Patient Clinics

The protection of individuals is of paramount importance in emergency rooms and out-patient clinics. Many clinics, for example, cannot safely function without guard coverage.

Nevertheless, a great deal can be done in the design and planning of these clinics to reduce opportunities for physical assault on the staff.

### Nurses' Residence

Whether the nurses' residence is part of the complex, or a separate building connected by tunnel or bridge, entrance to the residence should be monitored. Monitoring can be achieved by guard coverage. Good advance planning, however, can sometimes achieve effective monitoring without the additional payroll expense for protection of the nurses' residence. Such devices as closed circuit TV, surveillance, public address systems, various types of door alarms and other mechanical or electronic devices can often be used instead.



### Perimeter Security

Here a wide variety of problems and solutions are possible. There is little similarity between a rural or suburban hospital built on a large expanse and an urban hospital consisting of one massive building covering one or more city blocks. But the essential target for perimeter security remains the same regardless of the site. The complex is to be designed so as to inhibit an employee, visitor, or any person entering the hospital to emerge unobserved and unimpeded through a fire exit or any other door, window, air shaft, fire escape.

To attain this goal requires a comprehensive lockup system within existing fire regulations, supported by a practical monitor alarm system which deters and also exposes breaches of the perimeter.

### The Guard Force

It is rare that a guard post, whether fixed or roving, can be justified on economic grounds unless the guard is required to perform multiple security duties. It is usually difficult to justify a guard's exclusive attention to the monitoring of employee traffic, or the surveillance of patients in the emergency room, or to the watching of activities on the receiving dock.

However, if guard duties, coverage and schedules are formulated during the blueprint stage, plans can incorporate physical and procedural measures permitting guard flexibility which makes their costs tolerable.

### Conclusion

The presentation of these observations, of course, cannot be considered all-inclusive. This over-view of hospital security, it is hoped, will demonstrate that although the problems are complex, they are manageable through forethought and timing. Architects can make a contribution second to none in this grave and costly area by incorporating security considerations in their plans. Fortunately, some leading professionals are moving in this direction, but the response has been minor compared to the need. ■

# Design To Meet Patient Needs and Enhance Longevity of the Long Term Care Facility

By Joseph A. Koncelik

*Joseph A. Koncelik is Assistant Professor in the Department of Design and Environmental Analysis at Cornell University, Ithaca, New York. Mr. Koncelik is part of a team of designers and behavorial scientists involved in the evaluation of long term care facilities, especially the evaluation of how well the physical space meets the behavorial needs of the aging. This article was prepared to demonstrate some of the aspects with which the researcher is concerned.*

In the last ten years, the construction of long term care facilities has seen a veritable explosion of newly created buildings. Both State and Federal mortgaging programs have been created in order to fill the need for institutional beds and the replacement of others that are outmoded or beneath standard. Beyond the facilities already planned or in the building phase there will most assuredly be further construction in health related facilities and other types of housing for the independent and semi-independent elderly. These programs of building have been expensive. Although it is argued that only 4% of the aging population live in institutions, the cost to all age groups is very high.

How well has the nation done in meeting the needs of the aging population who inhabit nursing homes? Are the physical and emotional needs of the elderly being satisfied within the institutional setting?

The answer to these and other pressing questions does not come easily. At this moment; the patients, staffs, nurses, aids, administrators, and the designers are living with their successes and failures. In spite of the sophistication with which most construction is approached, evaluation after construction has taken place is not yet considered an important facet of the design process. There has never been a greater need for evaluating the facilities that have been created for the aging. In terms of economics, if the buildings fail to satisfy the needs they have been created to meet, America will again be faced with a massive building program. The longevity of the facilities constructed depends largely on the evaluation of relative successes and failures and making adjustments necessary to optimize the total care provided to the aging.

"Care" is an extremely difficult word to define for the long term patient. A part of any definition should be that any given facility should provide every opportunity for the patient to remain or regain independence; it should accommodate the disabilities of the aging patient, and provide impetus to the aging to retain or regain a functional outlook.

The cost of care is skyrocketing even beyond the cost of facilities that are constructed to provide care. If the nature of rehabilitation in the extended care facility is that of sustaining the patient at the level of admittance, there will be no stopping the inflation in health care costs for the aging. For every facility now functioning, a duplicate may be needed by the turn of the century if this concept of rehabilitation predominates.

In the interest of facility longevity, it would seem at first glance that increased demand for space is a desirable thing. This may not be very wise if present trends are only superficially studied. Increased demand has forced the construction of ever larger facilities and eliminated the smaller nursing home from the ranks of the certified. Obviously in the majority of cases, this was a desirable development. However, one can easily envision the decertification of nursing homes of the 100 bed variety a few decades from now simply because at that time, they will be outmoded, depreciating, and just too small. In other words, **we know not what we build!** Without evaluating the total building effort for the aging and how well these facilities meet their needs, it is impossible to say that the nursing homes presently constructed and under construction will last any longer than their predecessors.

### Assessing The Physical Environment

The planning and construction of nursing homes and other long term care facilities should include a portion of the budget allocated for evaluation of the completed facility in order to make the design process increasingly efficient. No builder, planner, architect or engineer can take

the time to evaluate their creation at present. The mortgaging programs are too limited to provide for this function —even though it is necessary to insure better building in the future. However, even if the money was to be made available, it is doubtful that the competencies of these professionals include assessing their own work dispassionately, objectively and expeditiously. Also, no professional in this group could provide the expertize necessary to follow up the evaluation of the facility over a long span of time. It is the role of this group to design and build. It is also the role of this group to act upon the best information available during the design process. Obviously there is a need for a new professional group that is equipped to evaluate environments created for the aging. In order to properly evaluate any physical environment, there must be an interlocking of the behavioral sciences, the physical sciences, and the design profession. There must be a synergistic effect between these disciplines; a wholeness emerging that is more than the separate entities, in order for any evaluative process to be born that will contain promise.

**How Can Patient Needs Be Studied In Relationship To The Physical Environment?**

One of the most obvious techniques that is frequently overlooked by many inspection teams and others studying the nursing home is to ask the elderly living there what they think of the place. It seems like a simple idea, but it is not. The object is to systematically gather data that will reflect the true picture of the facilities' merits and bad points.

An adult who is independent and in good health can be described as quite self contained: without need for attachments to his environment. With the onset of illness, this same adult becomes more dependent upon various components of the environment that provide support, protection and nurture. The ill-aging who are patients in nursing home facilities are in the second catagory of dependency. They are not only dependent upon the services of their facility, they are dependent upon the space and objects in that space for a supportive effect.

In a recent study conducted by a team of researchers from the College of Human Ecology at Cornell University, structured interviews, "behavior mapping" (an unobtrusive observation technique) and photographic studies were used to trace the effect of the physical environment upon the ill-aging who reside in eight nursing homes in upper New York State. It has been established that the spaces and the objects (furnishings, seating, etc.) within spaces are a determinant of behavior. This is not to say that the physical environment is the only factor in behavior or even the most important factor of the total environment. However, the relationship of the ill aged to areas they use throughout their livelihood in any nursing home will play a role in their ability to interact with others, remain as self contained as possible (or resume a greater amount of independence after acute illness), affect their own self image and thus their health, and contribute to their desire for activity and stimulation.

As an example of how this relationship may work, in one facility, an improperly planned and designed dining area was observed that did not make adequate provision for the large number of geriatric wheelchair bound patients that inhabit the facility. Tables of standard height were chosen. Too many standard chairs were arranged around the tables and not enough free space for the rather large wheelchairs to maneuver was allocated or left over from the arrangement of tables and chairs. Two resultant patterns of behavior emerged from this study: 1) many of the wheelchair bound patients could not find space and gradually drifted away from eating in the dining facility: choosing instead to dine in their own rooms or the hallways outside their room; 2) others that found space, found that eating at a standard height table in a geriatric wheelchair was difficult because of the resulting long reach to the table. The embarrassment felt as a result of this experience was substantial and a severe loss of face-owing to an acceptance of fault for not being able to negotiate feeding under those conditions—discouraged others from the use of the dining facility.

This is but one example of many, where a severe loss was experienced by both staff and the aging, because a space was poorly designed and planned with regard to its function. In the interest of longevity, there are two possible ways this interaction or "interface" could effect long term utilization of the facility. The first would be that the dining room should be changed in the interest of serving the greater number of patients who use it. This means further expense on the part of the management or owners of the facility. Sometimes, dining rooms that are not put to maximum efficiency are converted to multifunctional spaces that rule out group dining—hence the loss of one of the best therapeutic devices for the ill aging: interaction with others over the highly anticipated daily meals.

The second effect may be more profound. Any physical environment is a kind of mechanical organism with a life-like set of intradependencies. An unused dining facility means that the services distributed within that space must be redistributed on a less efficient and less hospitable basis. In other words, the total facility will probably be affected by the lack of use of the dining room. Another way to view the situation that exists is to see this breakdown in efficiency and environmental accord as symptomatic of other even more profound inadequacies of the facility. (If the dining area is falling into disuse, is the activity area properly utilized?) These and other questions could result from tracing the interaction of the physical environment and patient in depth.

Although no data has yet emerged from the afore mentioned study that suggests that nursing homes with one area poorly planned and designed have other or all areas in the same status, the possible consequences of this speculation are quite realistic. It is certain that with more study, sufficient information can be gathered that will test and validate or nullify this hypothesis.

The more obvious attachment of use of space and patient needs affecting longevity, is the problem of wear and tear of the facility through use. A component of this problem is how to minimize and expedite the maintenance operation within nursing homes. (There is another side to this issue that must also be discussed in order to see the full value of the organic nature of a facility. The maintenance operation should not only be viewed as simply that of keeping the spaces clean and in repair, but also as having a significant part in the care of the patient. Frequently, the arrangement of seating, the placement of beds within rooms, the permissable uses of spaces are dictated by maintenance policy and practice. The allignment of chairs, the choice of floor and wall coverings for the sake of expedient cleaning, even the number of light fixtures with operating

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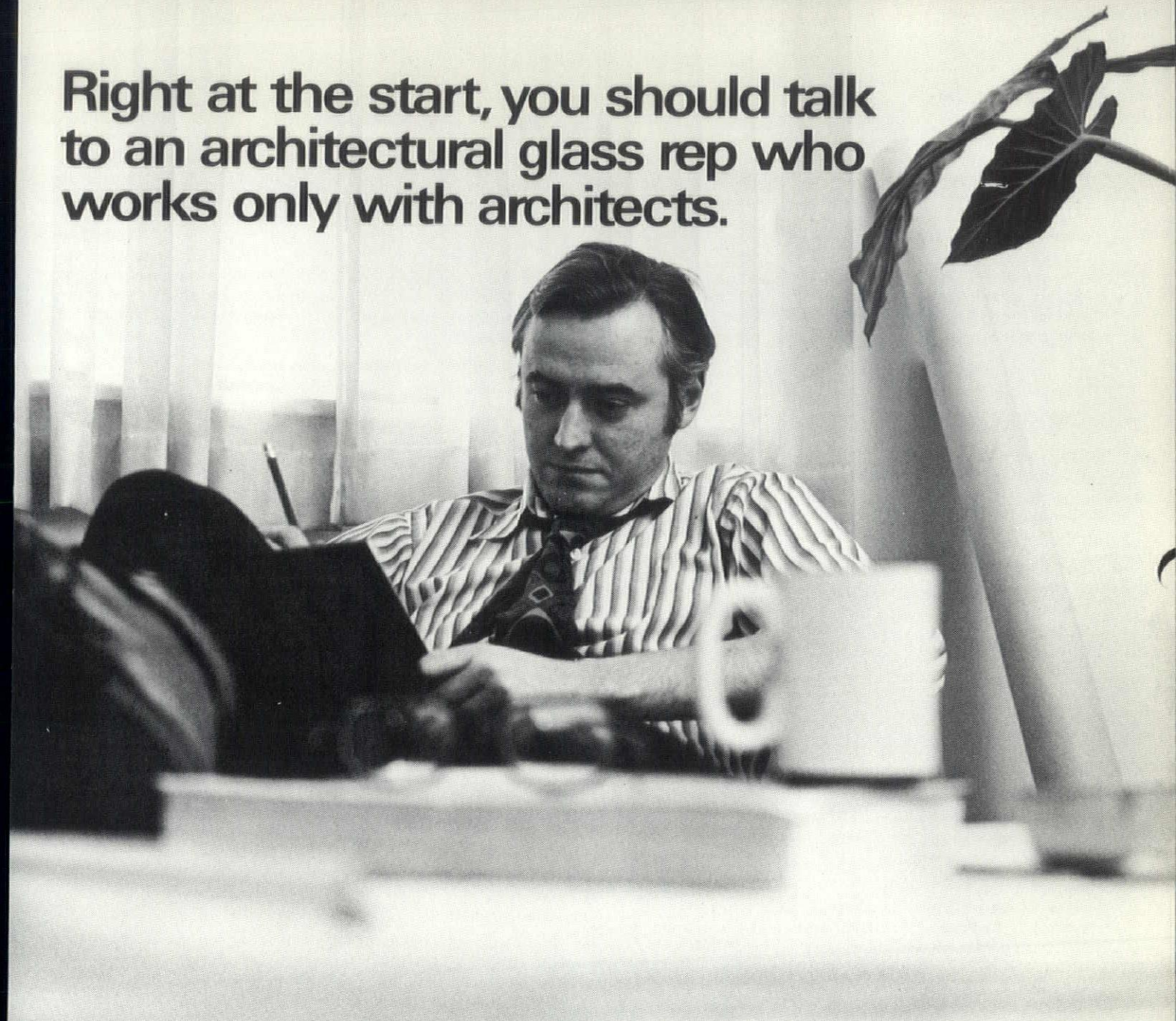

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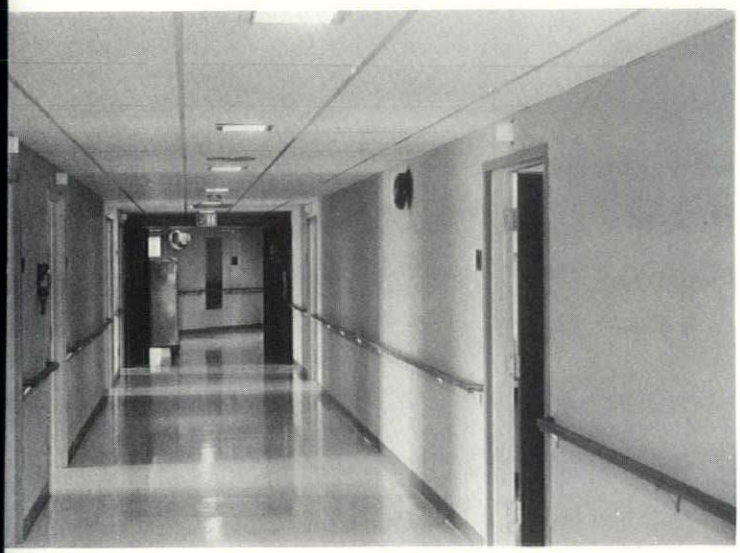
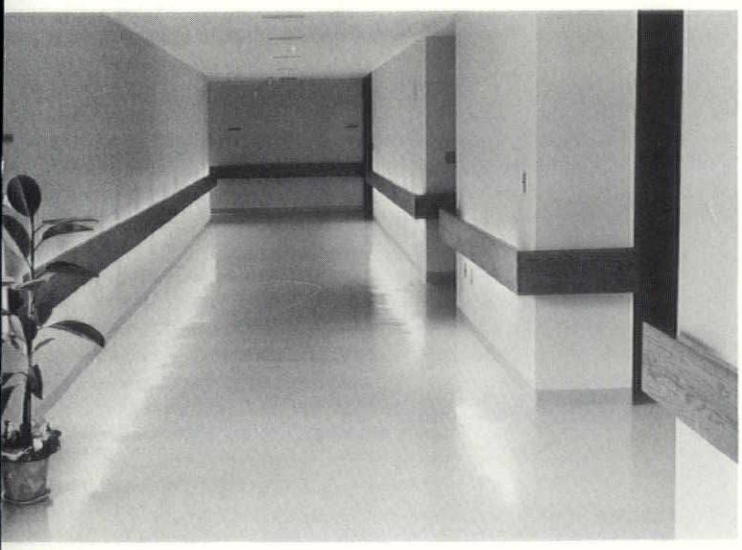
bulbs are often dictates that influence the behavior of the aging patient. It is extremely important for nursing home administrators to begin integrating the maintenance staff into the fold of the personnel that are responsible for the well-being of the aged who use "the" facility. In so doing, it may improve the total care concept and add incentive and status to the maintenance operation.)

The problem is the retention of a serviceable facility with all of the various uses that tend to degrade it physically. Again, evaluating use is one way to perceive the relationships that need restructuring or amelioration.

As an example, the handrail commonly found throughout the hallway complexes of various nursing homes may vary in height from the floor from 31" to 39½". The shape of the rail is very different from place to place. In one facility it may be basically a circular section, in yet another





*Two variations in the design of corridors—and thirty years difference in time of construction. The handrails are most striking in their difference of shape and location and the floors most striking in their similarity of intense reflection.*

it may be rectilinear. The widths vary greatly as well. This has obvious consequent effect on uneability; which is a factor that only further analysis of the Cornell data will reveal. It also has an effect on the care needed to preserve wall surfaces. Certain railings will allow the wheelchair or the walker bound patient to swing their respective ambulatory aids into the wall and scar the surface while others will not. This relationship of use to maintenance is compounded by the various types of surfacing materials found in various facilities. Some will use materials that are quite impervious to abrasion of this kind while others use surfacing that may be less expensive but far more vulnerable to damage.

One of the most unprotected areas of any nursing home is the doorway. Negotiating a door of the size and mass of the variety found in most nursing homes is difficult for the wheelchair bound patient. Even though their width has been determined to allow passage of the wheelchair, the larger the door the more difficult it is to swing open from the seat of a wheelchair. Hence, observation will often reveal deep surface mars on doors where there is substantial wheelchair traffic. Damage will also accrue on doors to private rooms where a patient is wheelchair bound. It is not necessary for traffic to pass through a door for there to be damage to its surface. The handrail ends at each doorway and this means that the patient in a walker or wheelchair must use some maneuver that is slightly different to progress pass the door using the handrail. This often means the ambulatory device scrapes the door on the way by.

These things may sound like over emphasis on detail, but one need only enquire about the price of a fire-rated 46" or 48" door, probably inserted within a steel frame, to ascertain that replacement of perhaps 200 of them throughout a facility is a costly affair. Better design and planning at the onset coupled with information from evaluation efforts in research could do much to rectify the initial problem.

Another area of concern from the standpoint of longevity is the coming effort in accident prevention within nursing homes. The evaluation team has recorded several examples of accident producing design that should have been avoided in the initial planning program. Some examples include: doorways that swing inward onto shallow stair landings where someone, blind to a person on the other side, could potentially knock that person down the stairs; hallways that provide no means of allowing patients or staff in adjoining halls to see traffic they will conflict with upon entering the hall (most geriatric wheelchairs can be pushed almost 30 inches into a hall before the person doing the pushing is aware of the traffic they are entering; nursing stations so positioned that perceiving any difficulty in the halls to either side is practically impossible without leaving the station and entering the hallways.

There are other less tangible, less objective facets of the present day nursing home that will also play a role in their subsequent longevity. The aesthic quality of even the best facilities is all too sterile: molded upon a hybrid notion extracted from the character of acute care hospitals. A nursing home is something less than and, at the same time, something more than a hospital. There are obviously components of the nursing home that are very much a part of

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LONG TERM CARE— continued

health service. However, there is no reason for the barren clinical aesthetic that has been established as a model. There is sufficient reason to believe that as more is learned about nursing homes, including their design relating to patient needs and their behavior, this model will change and subsequent construction will change.

### Conclusion

There is a tradition in America of tearing down buildings even before their useful life has extinguished. One need only look at pictures of the New York City skyline over a period of ten or twenty years to see the incredible change in just that one location. There is little difference in philosophy of building from place to place in America: only a difference in building speed. Thus, with even the best of intentions in the construction of housing and health care facilities for the aged, the longevity of these structures may still fall prey to the same demolition syndrome that pervades our culture.

The point of this article, however, is that even if present construction for the aging was built with the best possible intentions, evaluation of the physical environment/patient interface is showing that many of the needs of the aging within these facilities are either not being met or are in conflict with the overall design. It is hypothesized that eventually many or most nursing homes will have to be modified—if possible—to accommodate the human functions they are presently not accommodating. This hypothesis is not to be construed as basically an anti-institutional agrument. The author accepts the concept that institutions for the ill aging are the most economical, expedient and efficient means of delivering health care services that they need, and, for the most part, cannot exist without. However, all who engage in planning and designing these facilities should be forwarned that a new model of design must be carefully put together based upon the needs of the ill-aging and the independent aging if the length of life of existing construction and new construction is to be maximized. This model can be accomplished through the cooperative evaluation of existing facilities: cooperative evaluation in that nursing home staffs and administrators need the objectivity of outside experienced evaluation teams as well as their own self evaluative efforts.

The significance of the nursing home in relationship to contemporary society is extremely important. There is a greater and greater tendency to institutionalize ever more of the life span in various ways. The small percentage of the aging who exist within institutional surroundings represent, in effect, the rest of society of the future. The success with which their needs are met will greatly determine how well everyone's needs are met in time. ■

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